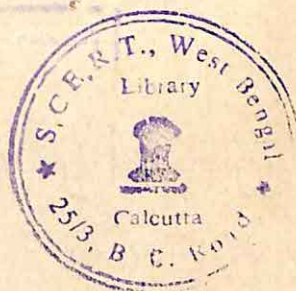


# ABNORMAL PSYCHOLOGY

by  
HANS RAJ BHATIA



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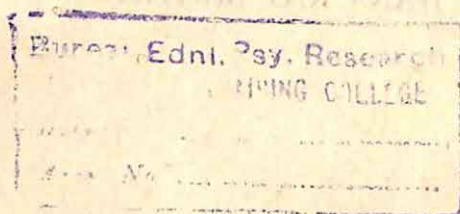
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Samaj Manovigyan.

## PREFACE

This is a simple elementary book on abnormal psychology which will meet the requirements of both the professional students offering this subject for the B.A. examination of Indian universities, and the lay reader who may wish to know and understand some of the abnormal types of human behaviour. Students of nursing and medical colleges, training colleges and institutions training young people for social work will find it very useful in so far as this book will reveal to them that in abnormal, diseased or anti-social behaviour there is another aspect of personality which must be taken into account for treating people. There are very few books on this subject published in our country and the present book written in direct, simple and easy language and yet embracing all the essential facts and principles of this branch of psychology will be found very helpful. Quotations have been carefully avoided, except where there is need of adding weight to facts and as far as possible examples from Indian life are cited. Questions have been added to each chapter to pinpoint the important facts and so that students may check up on what they have read. They are not necessarily of the examination type.

The lay reader will find much that is new to him, and after reading the book he will find that the behaviour of his friends and his own shows itself in new dimensions which he had never envisaged. And may be that this understanding helps him to have a more charitable view of how others behave and act. Most of the queer and strange ways of our friends and relatives have a history behind them, and may be the reader is able to guess that history after a perusal of this book. If a person goes on washing his hands and mouth for too long and with a frequency which is abnormal he is not being mysteriously queer, he is just trying to express his feelings of guilt though he is not aware of them. He must have repressed some memory which is unpleasant but which is bursting out.

The author ventures to hope that both types of readers he has in mind will find the book helpful and interesting. Any suggestions for the improvement of this book will be gratefully acknowledged.

Jaipur,  
15th March, 1968.

Hans Raj Bhatia.

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# ABNORMAL PSYCHOLOGY

## CHAPTER 1

### The Nature and Scope of Abnormal Psychology

*What is abnormal psychology?*

General psychology studies human nature and behaviour, and abnormal psychology studies abnormal behaviour, that is, behaviour which is different from normal behaviour. In a way we are all different from each other but abnormal psychology studies behaviour which is different in an undesirable sense. We all wash hands and each of us washes them in a different manner but a few people continue washing them over and over again. We all suspect things and people but some persons are suspicious of everybody including their own family and some suspect that everybody, even their own kith and kin, are plotting to do them harm. We all worry and feel anxious about things but some people are worrying all the time that something terrible is going to happen to them. We all feel angry when we are obstructed but some people begin trembling in anger, strike things and people or refuse to talk and deal with those who have roused them. Such people excite comment because their behaviour is unusual, strange, queer, eccentric, silly, different and away from the common and the normal.

The above examples are of mild abnormal behaviour, but we have cases of behaviour which is very difficult, which prevents people from doing work to their own or society's advantage, from managing their own affairs, from looking after their safety and well-being, and from meeting the problems of life full in their face so as to solve them, and which needs care and treatment in special institutions. A person shrieks in fear when left in the dark, another is terror-stricken when asked to go up a high tower and still another grows pale and starts perspiring on seeing a dog. A college student gets nervous and queer, leaves his seat in the examination hall, walks up to the superintendent and misbehaves with him. He is judged to be suffering from a "nervous breakdown" and is sent to the "asylum". No more is heard



about him, he may have developed a serious mental illness. During the World War many soldiers were struck deaf and blind though nothing wrong was found in their ears and eyes. They needed psychological treatment and were treated and cured in specially organized hospitals. Some of these mental disorders and ailments last a lifetime.

There are a good many physical ailments which are really mental though the layman would not consider them mental at all. Many doctors would bear testimony to the fact that a good many people seek medical advice for physical disturbances and troubles which are really induced by psychological causes like extreme fear or anxiety. Their troubles are really mental though they have bodily symptoms and it is the responsibility of this new field of abnormal psychology to study them. It is a commonplace truth that doctors must know not only the bodily condition of a patient but also his mental condition, and an effective treatment of unusual, sick, disorderly, queer or un-social behaviour necessarily involves a very close study of his psychological conditions and background.

The study of abnormal behaviour is handicapped by one important factor. People who have some mental disorder or a strain of insanity, who are excessively irritable or depressed or who are inclined to worry too much about things, are the last to admit of such disorders or abnormalities in themselves. Since quite a number of them may reach a position of authority from where they can influence and affect the lives of numerous people, their behaviour, plans and programmes need a very careful study and analysis at the hands of the students of abnormal psychology. Biographers of eminent persons like Hitler and Napoleon have pointed out abnormal traits in their personalities.

The nature of abnormal behaviour would be better understood if we analyse in detail the basis of the distinction between the normal and the abnormal and describe in broad outline some of the major types of abnormal behaviour.

### *The normal and the abnormal*

How do we distinguish between the normal and the abnormal? What are the marks or symptoms of a mentally sick, disturbed



maladjusted person as distinguished from a person who is healthy, happy, balanced and well-adjusted? As has already been pointed out the layman only describes his own reactions to abnormal behaviour by calling it funny, queer, bizarre or terrible. "Crazy", "nuts", "hay wire" are some of the common slang words used for the abnormal person but the science of psychology is not content with such descriptions and seeks to formulate a yardstick or criterion by which the abnormal may be marked off from the normal. As it is a number of criteria are applied and we may discuss them.

The first approach is *statistical*. The normal represents the average and the abnormal represents the deviations from the average and the normal. It is possible to arrange people in terms of increasing intelligence, personality stability or ability to adapt themselves to social environment. It will be found that a large majority of people group round the central point indicating average or middle degrees, some possess these attributes in considerably less degree and are placed at one end and some possess considerably much more and are placed at the other end. Both are abnormal, that is, different from the normal. The former in being inferior and sub-normal, and the latter in being superior and super-normal. Only a small percentage of the total population lies at these extremes and is judged "abnormal", "pathological" or "deviants", but a much larger majority of people cluster round the central point of the average and are considered normal.

This statistical approach helps us in understanding the normal but is not without its limitations. People with violent fears, delusions or anxieties are sick and pathological, but genius and very bright people placed at the other end of the series are not abnormal in the same sense. To class genius with the pathological is not quite valid. Again many people, particularly women and children, at times show extremes of fear and anxiety and act in a manner hardly to be expected of a healthy, normal person. Should we, on that account, group them as abnormal? We will have to admit that some very abnormal traits may be present in normal people just as some healthy people may occasionally suffer from ailments like the



common cold or feverishness. Finally, the statistical approach assumes that people differ only in degree, that is, quantitatively, and that all traits can be measured and arranged in a series of increasing and decreasing quantity. But this is not quite true. People may have qualitative differences, for example, some men suffer from tuberculosis, others do not, some have bad throats, others are free from it. One class or group is affected by a mental disorder and the other is not. This is a difference in quality and averages do not help.

The *pathological* approach considers all persons suffering from mental disorders or ailments as abnormal. A normal person is healthy and effective and an abnormal person is unhealthy and ineffective. Normal persons do not have the thoughts and emotions of those who are mentally disturbed nor are they slow-witted like the imbeciles and the idiots. Extremely stingy persons who would not part with their wealth even to protect their health, extremely stubborn parents who would not listen to sane advice from their children, teachers who enjoy giving severe punishments to their pupils, newly married wives who commit suicide at the slightest provocation from their husbands, those who cause undue damage to property or break down in times of stress or in face of acute hunger and the like are examples of mental illness and are, therefore, judged abnormal. But it will be readily admitted that there are qualitative differences among the pathological and these are not explained by this approach. Nor is this approach able to explain the difference between the normal and the superior or extremely bright people.

Lastly, it is not possible to understand the distinction between the normal and the abnormal without reference to the cultural background of the people. The *cultural* approach in distinguishing between the normal and the abnormal is, therefore, very important. Humble, cringing, self-denying behaviour is normal among Hindus but would be considered abnormal in the aggressive and competitive climate of the West. Every culture has its norms and conformity to them is held normal and non-conformity to them is held abnormal. Kissing one's mother is held normal in the West and abnormal in India. Wailing and crying in public over the death of a relation is deemed normal in



India but would be considered abnormal in England and America. This is what we mean when we call the abnormal undesirable, that which is not liked and approved in any social setting or culture. Thus cultural backgrounds have to be taken into account in distinguishing between the normal and the abnormal.

We may also add that what is normal for an individual also depends on his age, social status, sex and the like. Young boys normally dance, throw their caps and shout in joy when a football match is over but such a behaviour in grown-up people would be considered abnormal. And if young boys did not behave like that it would be considered abnormal. What people of lower classes do would be abnormal behaviour in people of higher status. What is normal among men may be abnormal among women and vice versa.

But it should be clearly understood that there is no sharp line dividing the "normal" from the "abnormal". You cannot place all normal people on one side and all abnormal people on the other, the healthy average persons on one side and the mad, eccentric persons on the other. Most people are moderately well-adjusted and normal but show abnormal traits; they lead healthy and happy lives but in moments of stress and strain break down. So also the so-called abnormal insane people may behave at times in a very normal manner. Sudden loss of job or business, death of a very dear relative, disappointment in love and similar shocking experiences may upset people and impel them to behave in an abnormal manner. They may not be able to meet the difficulties of life in a satisfactory manner. And people weighed down by depression and frustration, poverty and neglect, may start behaving like a normal person if they are promoted or given opportunities to improve their lot. Improvements in health, financial position or social status have made many disturbed and maladjusted people behave in a normal manner.

### *Types of abnormal behaviour*

What are the symptoms of abnormal behaviour, how abnormal behaviour is caused and how it takes place are questions which will be better understood if we make out a list of the several



types of abnormal behaviour. Here we have to deal with a very wide range of human activity and in several cases, as will be clearer later, symptoms in two or more types of behaviour may be similar. For example, intense form of irritability may be found in a person dead tired or in one with lowered efficiency, in a victim of extreme anxiety or of brain tumour. Such facts show difficulties in the way of a comprehensive classification of abnormal behaviour patterns. Several authors have put forward schemes of such classification but the one used by the United States Army has proved more satisfactory and is now being used in most of the recent text-books.

The Army classification with slight modifications divides abnormal behaviour into six major sections which are briefly described here. It is obvious that each of these major sections will have sub-sections and sub-groups but of these we shall speak later.

1. *Transitory personality reactions* : In times of great stress and strain many individuals break down and for some time behave in an abnormal manner as a result of the shock or as after-effects of tragic experiences. Involved in a railway accident, seeing a child killed by dacoits, pushed into a battle or riots or witnessing a harrowing tragedy individuals are shocked and grief-stricken, show neurotic and psychotic symptoms or give evidence of panic and nervousness. During the Partition of India people from the West Punjab were dazed and bewildered and could not behave in a normal manner. Loss of all that they had, property, hearth and home, dear and near ones, and uprooted from their soil they were nervous and panicky, lost their sense of dignity and behaved as if they were half mad. Such reactions do not result from any deep-seated malady but are aroused by some stress situations in which otherwise normal individuals are mentally disturbed and behave in an abnormal manner. Such people may recover soon, and only a few of them need treatment in a clinic. Their difficulties are temporary but they need the understanding and sympathy of those around them.

2. *Psychoneuroses* : Also known as neuroses these disorders are characterized by inner struggles, tensions, conflicts and disagreeable social relations. They are caused by acute

emotional stresses, frustrations and conflicts, and can be effectively treated by psychological methods. The physical symptoms are pains in different parts of the body, disturbances of digestion, loss of control over sensory and motor areas and the like. The frequent psychological complaints are anxiety, acute depression, inability to take a decision or to concentrate attention, extreme form of irritability, suspiciousness, lack of interest in their surroundings, loss of sleep, obsessions and inability to enjoy social relations. Such symptoms are extremely varied. These disorders are not caused by physical disturbances as is readily believed by the patient. Often he seeks drugs to cure his bodily ailments and fails to understand that they cannot be medically treated. They need psychological treatment. There is no need to send the patient to a hospital. At least nine types of psychoneuroses have been identified.

Ramnath feels always tired, his digestion is very poor, he is not inclined to do any serious work, he has no initiative, does not like company, often complains of severe headache and loss of sleep, and cannot concentrate on his work and study. He seeks medical advice and doctors advise him to take some tonic, go out for a morning walk, eat fruit, play some game or seek cheerful company. He may take sleeping pills. His health is going down and he is constantly harassed by fears and worries of all sorts. Medical treatment helps a little but does not go far. What he needs is the psychiatrist who may bring home to him what frustrations, worries and conflicts are playing havoc with him and how he should get the better of them.

3. *Psychoses* : These are much more serious mental disorders. The patient has no sense of reality, no understanding of his environment and his personality is entirely disorganized. Psychoses are generally of two types : *organic*, which are due to brain injury, disease or poison, and *functional*, which are due to extreme psychological stresses and organic disturbances. The patient is not able to think or speak coherently or to manage himself or his affairs. In fact he looks and acts as a different person, and needs regular treatment in a hospital or a separate home. Of course, such patients are not held accountable for their behaviour as they have no sense of responsibility nor are aware



of the consequences of their behaviour. Laymen call them by the common name of insane or mad but as we shall see there are several differences. Organic defects in such patients may be due to heredity or to injury in the brain because of toxic condition or accident. Symptoms of psychotic patients remain constant and the prospect of recovery is remote. Death-rate among such patients is high. They do not at all respond to psychological treatment and have to be medically treated.

4. *Character and behaviour disorders*: These disorders are the result of faulty development. The individual does not feel any anxiety and his disorder represents a lifelong pattern of socially undesirable behaviour. Some people mistrust everybody, others have an inordinate desire to dominate their fellow-beings, some people are always ready to neglect their own welfare and good for others, even their family is neglected. Some are given to pleasure-seeking and sensuality without regard to the interests of others, some are too rigid in their social relations and always keep insisting on certain norms and ways, some have an extremely intense desire to accumulate and hoard. These desires have been developed to an exaggerated degree and at the cost of other desires and goals. Such traits are anti-social. Deviations of sex are also included in this group. The individual has developed strong habits to behave in a certain manner in all situations. The miser will always think of saving and cutting down costs and expenditure whatever else he may miss or lose.

The more severe forms of anti-social behaviour are to be found among violators of law, the criminals or delinquents. All law offenders are not abnormal; people who are caught once in a while for violating the rules of traffic or travelling without tickets are quite normal people but hardened thieves, pickpockets, kidnappers of children and the like give evidence of deep-seated behaviour disorders. Some of them may have defective intelligence and, therefore, a weak civic sense, others may be psychoneurotic or psychotic. But there is one group which may be described as having psychopathic personalities. They have enough intelligence, they do not suffer from the anxieties and frustrations of psycho-neurosis nor do they have delusions and hallucinations of the psychotic. In



fact some of them are highly intelligent and have very pleasing manners, but they have no restraints, no sense of conformity and respect for the social laws. They are impulsive, selfish, unstable and inclined to satisfy their desires immediately they arise without any regard to social propriety or law. They have no moral or social scruples and selfish advantage is all that they seek. Often they know and understand their abnormality but they have no wish to improve and reform. Usually they are more severely punished in view of their intelligence and seeming normality, but they also need understanding and sympathy and better treatment.

5. *Disorders of intelligence* : Some people because of their defective intelligence are unable to meet the demands of social living and make suitable adjustments to environment. Such handicaps are due to brain structure and heredity, and not to any emotional or mental difficulties. Intelligence tests reveal that all people with an Intelligence Quotient below 90 are feeble-minded. They cannot manage their own affairs nor can they support themselves, and they are a liability to the family and society in which they are born. Feeble-mindedness due to heredity should be distinguished from that which goes with psychoses. The latter is often the result of brain injury or poison entering into the brain. Very bright feeble-minded persons are able to read and write and do benefit by schooling up to primary classes. They can learn a trade or manual skill and may with useful training be able to look after themselves and earn a living. Their companions often exploit and cheat them. Some of them may commit petty crimes and sex offences. They do not understand their social responsibilities and have to be supervised. Some of them may drift into regular crime and may become tools in the hands of crooks. Mental deficiency is often the cause of anti-social behaviour and some hold that crime is mainly due to defective intelligence.

Feeble-minded people who are very dull and whose Intelligence Quotient falls below 50 are not able to avoid danger and protect themselves. They have less intelligence than animals and would die if they were not constantly protected. They may not be able to walk, talk or feed themselves. Their place is definitely



in an asylum meant for them though a good many are kept at home. They cannot learn anything.

6. *Alcoholism and drug addiction* : Alcoholism and the habit of taking drugs like opium, cocaine may be the cause or effect of mental disturbance. Many people who are addicted to alcohol and drugs have a lower efficiency, both bodily and mentally, lower resistance to fatigue and disease, dull thinking and memory and diminished emotional stability. And, of course, many people take to alcohol and drugs to compensate for unfulfilled wishes, particularly of sexual nature, to drown their anxieties and worries and to forget themselves.

Taking alcohol or drugs over a long period of time may lead to decay of mental functions and psychotic reactions. The patient passes out into delirium or sees hallucinations. In America one out of every 200 is expected to develop alcoholic psychosis at some time during his life.

Marking off abnormal behaviour into several distinct types does not mean that it is always easy to classify patients or people with abnormal behaviour. Each person reacts and behaves in his own unique way and his reactions and behaviour may not let us place him in any one type. Frequently there is a difference of opinion as to how a patient should be classified and there is difficulty in the diagnosis of his trouble. It is possible that more than one kind of mental disorder is present and the treatment has to be adjusted to all of them.

### *Abnormal psychology in theory and practice*

We may define abnormal psychology as the study of abnormal behaviour with a view to understanding the symptoms and causes of the several types and indicating the lines along which patients of several mental ailments and disturbances are to be treated. Our interest may be entirely academic and theoretical. But there are people who are interested in using the techniques and findings of abnormal psychology in the study, diagnosis and treatment of mental patients. They are of two types, *clinical* and *consulting psychologists*. The work of clinical psychologists lies mostly with young children and adolescents. They have a fairly adequate grounding in principles and methods of

general psychology as also of abnormal psychology and abnormal disturbances and disorders. They give young people intelligence tests, educational and vocational tests, and find out if young people are pulling their full weight in studies and learning. They also help in identifying mentally deficient children and give them proper guidance, in studying their disabilities in several school subjects, correcting minor speech defects and removing difficulties of emotional adjustment. They also advise as to the aptitude of young people for different professions and courses.

The function of the *consulting psychologist* is to render professional service of a specialized kind. Some are able to advise industry about problems of personnel, welfare and efficiency, others treat minor disturbances of personality and behaviour.

The *psychiatrist* is a medical specialist who deals with the prevention, diagnosis, treatment and care of patients suffering from mental disorders. There may be difficult cases of psychopathology with or without organic complications which need administration of drugs, surgery or care in a hospital. Later in this book some of the important techniques of psychiatry will be discussed in detail.

Some psychiatrists use the method of *psychoanalysis* in the diagnosis and treatment of mental disorders, particularly psychoneuroses. All those who rely on the method of psychoanalysis hold certain very definite views on the origin and treatment of mental disorders. We shall discuss the theory and practice of psychoanalysis in greater detail later.

### *Abnormal psychology and related fields*

We will now discuss how useful abnormal psychology is in various areas of life and study.

*Medicine* : Since bodily disorders may cause mental disturbances and mental disturbances may lead to physical troubles, the relationship between abnormal psychology and medicine must be very close. It has already been pointed out that psychiatry involves a good deal of medical treatment both by drugs and surgery. Modern approach in medicine recognises the importance of psychological factors in physical ailments. Recently an eminent medical man in the United States remarked that



60 per cent of his patients seek medical advice for physical ailments which are really psychological. Doctors today are realizing that illness and disease is often complicated by emotional reactions and they must provide for the treatment of both. As we shall see later in this book a number of physical disturbances are really psychological troubles in disguise, the bodily symptoms are due to emotional stress and mental disturbance. A healthy mind in a healthy body and vice versa is no longer a hackneyed advice which school masters hand over to boys off and on but a sound psychological truth, and a recognition of mutual dependence of mind and body has given birth to a new branch of medicine called *psychosomatic medicine*. Many diseases like ulcers of the stomach, asthma, allergies, headaches, heart disturbances are considered to be caused by both mental and bodily factors. When modern doctors speak of the great need and importance of the patient's co-operation in effective treatment of any physical ailment they admit that the case is partially psychosomatic and the psychological attitude of the patient must be taken into account if medical treatment is to succeed.

*Education :* 'The aims and objectives of education emphasize the fullest possible development of all the talents and abilities of the young people and an understanding of the major mental disorders will be of great help to education. Teachers have a great opportunity of knowing and influencing their pupils and if they are equipped with a knowledge and understanding of abnormal psychology they would look out for early signs of any abnormal behaviour in children and take steps to prevent and correct the development of neurotic and delinquent traits in them. Most of the anti-social people develop such tendencies in the formative years of school life and care and advice given in time will avert later disaster. Many schools in the West employ wholtime psychologists in schools to render psychological service described above to young people. This is called *psychological counselling*. A number of teachers have personality problems. Some of them are too touchy and fly into a rage at the slightest provocation from their students, some have a very timid approach to life and work, some have very funny ways of speaking and acting in the classroom. Such types of abnormal



behaviour make them unhappy and interfere with their work. And there is a danger that such abnormal ways of acting, speaking and behaving may be transmitted to students.

*Mental hygiene* : The close co-operation of abnormal psychology and education in thought, if not in practice, has helped to strengthen the *mental hygiene* movement. The educational objective of physical health is now made stronger by the concept of mental health. Young people should not only be strong in body but also in mind, which means, that they should be able to meet the problems, frustrations, challenges and defeats of life with courage and fortitude and develop healthy mental and emotional habits. They should be free from minor faults of personality. And statesmen too are realizing that the nation should achieve not only maximum of physical health but also for meeting the challenges of the modern world and for effective participation in co-operative enterprises the people should have vigorous, hopeful and healthy ideas. Mental health is as vital as physical health. Any programme of promoting mental health will have to be based on our growing knowledge of abnormal psychology.

*Religion* : In several countries in the past the care and treatment of mentally diseased people was in the hands of priests and they were lodged in temples. In some countries they were believed to be inspired by God and were held in great esteem. In the middle ages Christianity believed that abnormal and insane people were possessed by the devil which could be compelled to leave if he were made uncomfortable by giving the patient severe corporal punishment. Accordingly such patients were given regular beating. With the growth of modern medical science such ideas have been replaced by scientific care and treatment of abnormal people, and priests too have realized that for giving peace of mind to people they must draw upon abnormal psychology and help in solving emotional and adjustment problems. People seek advice from saints and seers when they are torn by conflicts and frustrations of life, and a knowledge of abnormal psychology will help in understanding and administering to their needs. A good many mental hygiene clinics in the West are working under the supervision of priests or are attached to churches.



Again some fanatical religious reformers who believe that they have been expressly chosen by God to convert people to their own faith are really suffering from the mental disease *paranoia*. Frequently such faiths are fantastic and sensualistic and these reformers call for sacrifices which are quite unusual. Greater popularity of the knowledge of abnormal psychology will serve to correct the programmes of such fanatical paranoids and lodge them in mental hospitals rather than let them exploit the simple credulous people.

**Law :** All those who are engaged in the administration of law and justice must know and understand the mind and behaviour of the criminal and the psychopath. A psychiatrist may certify that a particular person must be sent to a mental hospital but because such a course bears on the freedom of the person concerned the final judgment must be made by a court of law. Patients cannot be detained in mental hospitals without legal authority. Besides mentally ill people are not accountable for their criminal behaviour in a law court and many try to escape conviction by a law court by making out a plea that they are insane. Those responsible for the administration of law must have a working knowledge of abnormal psychology to be able to analyse and examine such pleas. Nor are insane people allowed to manage their own affairs and in disputes about family property one party when nothing avails pleads that the other party is insane and incapable of looking after the property. Thus legal authorities must have a working knowledge of the symptoms of abnormality and insanity.

**Sociology :** The sociologist studies group behaviour as determined by cultural factors and the effects of social and cultural influences on the normal functioning of the group. We have already pointed out that certain forms of behaviour are normal in one culture and abnormal in another. In the study of community and group behaviour sociology will draw upon abnormal psychology for an understanding of neurotic behaviour and to see if cultural factors are contributing to its incidence. In India such phenomena as communal riots, students' strikes and violence, suicides and the like need investigation. Their influence on personal behaviour is not healthy and they may be due to frustrations and conflicts in the minds of people or their leaders.

During the last twenty years a number of institutions have been set up in this country for the study of social problems and for training people for social work. How backward we are in almost every type of community living makes such programme very urgent and important. In correcting and reclaiming delinquents and deviants back to normal life the social workers will find a knowledge of abnormal psychology very handy. In dealing with delinquent children who take to crime early in life, with beggars and petty offenders, or with young women who leave home to indulge in sex offences abnormal psychology in revealing to them the motive powers of such abnormal behaviour will equip them better for their work. They will approach such offenders with understanding and sympathy, and their counselling will be more effective.

#### *Plan of this book*

The various types of abnormal behaviour will be described in detail. How they arise, what are their symptoms and forms, and how they can be treated and similar topics will be taken up later. As abnormal behaviour is an extension, exaggeration or diseased condition of normal behaviour a detailed analysis of the dynamics of behaviour, the needs and motives which arouse it, frustrations, and adjustments made by individuals to overcome those frustrations, the nature and formation of personality, conflicts of motives and tensions arising from them, complexes and the unconscious motives, will have to be dealt with for a clear background of abnormal behaviour. While discussing each type of abnormal behaviour the type of specialized treatment of the same will be mentioned, a general discussion of the main trends, types and methods of psychological treatment will also be included. It would be equally interesting for the reader to know how abnormal psychology has grown and a brief account of the history of abnormal psychology from simple beginnings in the past to modern scientific thinking of today will also be very helpful and follows in the next chapter.

#### QUESTIONS

1. What is the nature and scope of abnormal psychology?
2. How would you distinguish between normal and



abnormal behaviour? Give three instances of abnormal behaviour you have observed among your friends.

3. What is the basis of distinction between normal and abnormal behaviour?
4. Describe some of the major types of abnormal behaviour. What types can be cured?
5. How is abnormal psychology related to education, medicine and sociology? Discuss.
6. What is mental hygiene?
7. How is abnormal psychology related to law and religion?

## Historical Development

Like every other branch of knowledge abnormal psychology has grown from magic to science through religion. The earliest notions of abnormal behaviour were that it was caused by witches and spirits. Though authentic cases of psychotic and neurotic behaviour have not been recorded in history, their mention in the literature of olden times shows that the problem of abnormal behaviour was always there and the plea that it is due entirely to modern industrialized ways of life is not quite tenable. The literature of several countries is full of examples of abnormal behaviour of many kinds.

For one thing in ancient society in all countries the conditions were such as to breed mental illnesses. Discipline in schools, religious places and workshops was much more severe and almost inhuman; the position of women and slaves was very low, they had no freedom and their lives were odes to serfdom, frustration, torture, deprivation and poverty. And all psychologists are agreed that these are just the type of conditions which breed mental illness. Religion in the middle ages was very exacting, monasteries and nunneries practised wholesale repression on young people and the severe punishments they had to suffer for very slight faults must have had a very unwhinging effect on their minds.

Based on the demon theory of abnormal behaviour the treatment generally consisted of flogging the patient, immersing him in icy cold water and other shock devices of very crude type. It is from these ideas that our modern "shock therapy" seems to have developed. Even modern brain surgery seems to have been practised in a very crude form in the olden times.

At least for one practical consideration that the ancient beliefs and practices have to some extent inspired our modern concepts of understanding, diagnosing and treating abnormal behaviour, and that the latter are a development of what people thought and did in the past, a study of the historical



development of abnormal psychology through the foregoing centuries is called for. It may not only give us insight but also indicate the direction in which psychology and psychiatry have been moving in the past.

### *The primitive approach*

Primitive thinking was very different from the scientific thinking of today. While today we look out for causes and laws of their working, the primitive resorted to magical animism that all things and living organisms move by virtue of the spirits dwelling in them, all movement is caused by the spirit or soul, even inanimate objects like stones and tools have souls which move them about. When things were going well it was because of the good spirit, normal behaviour was caused by a normal spirit. When things were going bad it was due to bad spirit or demons or ghosts. In death the spirit, ghost or demon left the body permanently, in dreams temporarily and in abnormal behaviour the demon or evil spirit took possession of the body. Insanity, therefore, was considered to be caused by demons or evil spirits taking possession of the body of an individual. Things happened by magic and were controlled by magic and, therefore, only some sort of magic could cure the insane, the evil spirit must somehow be enticed away from the body and the good spirit brought back. The primitive mind must have been exercised by meeting old buried people in dreams and the phenomenon was explained by spirits coming back to visit them.

### *Ancient civilizations*

In most of the ancient civilizations the belief that the insane and abnormal people are possessed by demons persisted and the type of treatment they suggested aimed at getting rid of the demon. The Chinese, the Egyptians, the Hebrews, and the Greeks all subscribed to the view that disorders of behaviour were due to demons which had taken possession of the individual. In fact natural events like earthquakes, fires, thunder, lightning, storms were also explained by demons. If a person got over-excited or over-active or showed behaviour contrary to what



priests expected of him, it was considered to be the work of evil spirits. The treatment for such demoniacal possession was exorcism, which consisted of prayers, incantation, drum-beating or noise-making and the use of various drugs and concoctions. In extreme cases of abnormal behaviour even flogging, starving or other measures were taken to make the body uncomfortable so that the evil spirit may be compelled to leave. Such treatment was usually in the hands of priests. In Greek temples often humane treatment was given and patients were treated kindly.

A Greek physician, Hippocrates, who has been called the father of modern medicine, denied the influence of demons in causing mental disease and insisted that mental ailments had natural causes and must be treated like other illnesses. He was the first to stress that brain is the seat of intellectual activity and mental illness is due to some disturbance in the brain, and that injury to brain may cause sensory and mental disorders, and that some mental disease is due to heredity. He classified mental disorders into mania, melancholia and phrenitis. For the treatment of melancholia he prescribed complete rest, a quiet and peaceful life, vegetable diet, mild exercise and avoiding excesses in all forms. This was a revolutionary idea and indeed Hippocrates was very ahead of his times. But in those days knowledge of anatomy and physiology was very meagre and Hippocrates had to fall back on crude ways and ideas. Yet he paved the way for later scientific treatment of mental patients.

Ideas of Hippocrates influenced the later Greek thinkers and though progress was slow mental patients began to be given more humane treatment. Plato and Aristotle pleaded that mental disorders were partly organic and partly moral and enjoined the family to look after members afflicted with mental illness. They, however, argued that reason was above disease and it was only lower functions which were disturbed. As yet there was no suggestion that mental illness could be caused by psychological causes.

Later Greeks and Romans did not make any fresh contribution to our knowledge of psychopathology but the idea gained ground that mental patients should be kept in pleasant surroundings,



fully engaged in some work or entertainment. Romans insisted on nourishing diet, light exercise and massage for the mentally ill as well as bleeding and purging. Greek and Roman ideas of medicine passed on to the Arabs.

### *Middle Ages*

The Middle Ages saw the rise and spread of Christianity and complete eclipse of the few positive discoveries of Greek science. Christian dogma ruled all thinking, all behaviour was considered to have been caused by the God-given soul. Demonology explained all abnormal behaviour, only the demon was replaced by the devil. All treatment of mental disorders consisted in measures by which the devil could be coaxed out of the body. In the beginning treatment consisted of prayer, holy water, sanctified ointments, the breath of priests, visit to holy places, touch of holy relics and the like. But this gentle treatment was soon replaced by more severe measures in the belief that the devil must be punished and humiliated, insulted and disgraced. Most ribald abuse was hurled at the insane person assuming that the devil was receiving it, curses and obscene insults were sure to expel the devil. Such treatment was in the hands of the priests and mentally ill persons were lodged in the churches. But the fanatic Christians carried their belief to tragic extremes and flogging, starving, chaining, immersion in hot or cold water and other methods of torture became the order of the day. The Middle Ages saw some of the worst forms of torture in the name of religion to punish the devil. Such brutal methods made even mild cases of mental disorder worse and what little hope mental patients had of recovery was lost.

Later theological beliefs took a turn for the worse. The insane were divided into two types, those who were unwillingly possessed by the devil as a punishment by God for their sins and those who were in conspiracy with the devil to win supernatural powers. The latter could cause epidemics, famines, storms, damage to crops, floods or injuries to their enemies and, therefore, were more severely punished. They were judged heretics and witches and were burnt alive. Some of them were tortured to confess before they were led to the stakes.



*Protesting skeptics and humanitarians*

In the latter half of the sixteenth century some eminent medical men, thinkers and even priests began to question the validity of satanic possession of the mentally ill persons. It was a great risk as the State backed such fanatical beliefs and all those who questioned them were punished with death by burning. Even then intellectuals like Johann Weyer and Reginald Scott did expose the fallacies of witchcraft and demonology.

At the same time people began to see the cruelty and barbarity of treatment given to mentally diseased persons but it was not before the middle of the eighteenth century that the first mental hospital free from chains and torture was established in France by Pinel and the insane began to be treated as sick people rather than as sinners. He recognised that the first step in the treatment is changing the environment and making it more congenial. This humanitarian approach spread to England under the leadership of William Tuke and hospitals for mental patients began to be built. The movement spread to other civilized countries and though it did not mean any progress in the scientific study and treatment of mentally disturbed people it offered them more humane and gentle treatment.

*The somatogenic view*

Gradually beliefs in satan's possession of the abnormal person were replaced by a more rational and scientific view that mental abnormality is a definite disease which may be traced to brain pathology. This view is called *somatogenic*. Even today many psychiatrists hold that brain injury is the only cause of all mental disorders.

The first systematic presentation of this organic viewpoint was made by the German psychiatrist, William Griesinger in his text-book, *The Pathology and Therapy of Psychic Disorders*, published in 1845. He insisted in this book that psychiatry should proceed on a physiological and clinical basis and that psychopathology should be reduced to brain pathology. His follower was Emil Kraepelin. His system of classification was the most important, he noted that certain groups of symptoms of mental illness occurred together with sufficient regularity that





they should be regarded as belonging to specific types of diseases, and he then went on to give a description of such mental diseases. This was no small achievement but it put psychiatry on the map of well-defined fields of knowledge. His classification and descriptions are considered authoritative even today. Another important contributor to the somatogenic or organic viewpoint was Krafft Ebing of Germany (1840-1902) who wrote an important text-book on the treatment of sexual perversions as a medical problem.

Thus the new viewpoint finally overcame the old approach of magic, superstition and supernaturalism, and established that mental disorders must be treated scientifically though only through brain pathology. For general paresis and certain other mental disorders definite brain pathology had been discovered and suitable method of treatment found. Mental illness had been put alongside physical illness, and the mental patients began to be given humane and gentle care and treatment in hospitals. A good deal of research into brain pathology was started on the basis of rapid advances in anatomy and physiology and the role of organic processes in mental disorders began to be more clearly defined. But of still greater importance was the achievement of public education that insane and mentally ill persons need understanding and sympathy, systematic care and treatment in well-organized institutions.

This viewpoint raised hopes that soon brain pathologies for the several forms of psychoses would be discovered and definite treatment and cure would be available. But any student of psychology will see that all this was only half the truth and that the mental side had been ignored. Such disorders were also a psychological problem. But the psychology of the eighteenth and nineteenth centuries was too naive and old-fashioned to provide a helping hand in the diagnosis and treatment of mental disorders.

### *The psychogenic viewpoint*

The question which puzzled scholars was : why one patient of paresis caused by brain pathology became too cheerful and the other too depressed. The solution of such a problem called for reference to psychological concepts and processes. Again in



several patients there was no organic defect or the brain defect was too small, in fact, so small that it could be found even in normal persons. Many workers in the field were discouraged and fell back on the position that such deviations were due to heredity. But this could not provide any basis for treatment.

Early in the twentieth century a new current of thought challenged the old view that all mental disorders were solely caused by brain pathology. There might be psychological factors causing mental disorders. According to this view life is full of strains, frustrations and conflicts and when they become so severe that the individual cannot meet them satisfactorily he resorts to the use of responses which lead to unhealthy adjustments. A student who fails in the examination in every attempt may become extremely discouraged and depressed or he might start blaming examiners that they are negligent, partial or corrupt. It might become very serious and grow into a mental illness.

In the beginning of this century psychology was still in its infancy and had not yet developed into a well-defined science. Though psychologists were working hard in this direction the psychogenic viewpoint was established through the study of *hypnosis* and *hysteria*. Fortunately these studies were made before the World War I and numerous cases of mental sickness were treated psychologically. When this was accomplished psychopathology found its two feet, and the medical profession began to admit that there were certain cases of real mental disorder which were brought about by severe psychological experiences and which could be treated by other psychological experiences. In such cases there was no brain or organic injury involved. For some time a great controversy raged between two viewpoints, one insisting that all mental illness is brain sickness and that for every type of mental disorder some underlying brain injury could be found, and the other protesting that some mental disorders have no underlying brain or organic disease or defect, that they are caused by purely psychological experiences and factors, and that they can be treated by purely psychological methods. Later studies showed that there is truth in both views, and that it is not desirable to separate organic and psychological, bodily and



mental, factors. An individual is both body and mind, and in understanding, diagnosing and treating mental disorders both organic and psychological approaches should be combined to know all that there is to know about the individual.

Before we take up the development of this whole and synthetic point of view let us trace developments in the study of hypnosis and hysteria which ultimately established the psychogenic viewpoint.

### *Hypnosis*

Hypnosis is a trance-like state resembling sleep in which a person readily accepts and obeys the suggestions made by the hypnotist. It may be described as an artificial sleep induced by the hypnotizer. It is a state of very deep suggestibility in which the hypnotized individual goes into a sleeping state, loses immediate consciousness or his own consciousness is overpowered by the consciousness of the hypnotizer and he performs the most varying tasks according as the hypnotist suggests to him. When he regains consciousness he remembers nothing of what he did in the hypnotic state. During hypnotic state he may not feel pain if the hypnotist so suggests and may recall experiences which he cannot recall in his normal state.

Hypnosis was known in olden times too but it was considered supernatural and attributed to some hidden magical power. Often the hypnotizer was accused of witchcraft. He also did not understand the source of his power.

Our scientific interest in hypnosis began with Mesmer who opened a clinic and started treating patients by what he called "animal magnetism" and by what later came to be known as "mesmerism". An impalpable gas or fluid was believed to effect this. The room was darkened, suitable music was provided and the patients were touched with a rod which was supposed to have that power. Mesmer himself appeared in a lilac robe and was able to cure cases of anaesthesia and paralysis. But professional medical men condemned him as a charlatan and he was made to leave Paris. Perhaps Mesmer himself was not clear about the source of this magnetism and could not explain the cures. It was left to an Englishman James Braid to show that there is no

such thing as animal magnetism and the removal of paralysis and anaesthesia was due to the suggestive effect of ideas aroused in the patient's mind by the doctor's words and gestures. No physical apparatus or paraphernalia is needed. Even a pencil or hypnotist's finger is enough to induce the trance. It is all a case of extreme suggestibility. Hypnosis was widely used as a help to psychotherapy throughout the early part of the nineteenth century. It was also used as an anaesthetic in childbirth. Two developments diminished its popularity. The discovery of ether and chloroform as anaesthetics and the growth of biochemical or physiological viewpoint by rapid advances in science made people feel that hypnosis was mysterious and magical to be used by quacks and charlatans.

At Nancy in France Lieubault continued to practise hypnotism in medical treatment. Another doctor at Nancy Bernheim along with Lieubault developed the idea that hypnotism and hysteria were related and that they both were due to suggestion. Charcot a well-known neurologist opposed them but in this controversy the psychogenic viewpoint received great attention and was firmly established. It began to be generally recognized that mental illness is psychologically caused and research was directed at uncovering the psychological factors in morbid anxiety, phobias and other mental disorders.

### *Hysteria*

Hysteria has a long history and its characteristic symptoms are paralysis of arm, inability to hear, feeling no pain in certain areas of the body even when a pin is stuck and the like even when there is no organic defect. Now it was found that such symptoms could be induced in a normal person by means of hypnosis. The second fact which was stressed is that such symptoms could be removed in hysterical subjects by means of hypnosis so that the patient could use his arm, hear or feel pain in the previously insensitive areas. Thus it seemed that hysteria turned out to be a kind of self-hypnosis. Charcot was a very influential doctor of his times and he did not accept this view for a long time. It was the Nancy school of doctors led by Lieubault and Bernheim who came out victorious in the controversy and the final view



prevailed that hysteria was the result of self-hypnosis on the part of the patient. Charcot too was converted to this view and later co-operated in research in this direction. Pierre Janet did much to popularize the psychogenic viewpoint.

### *Sigmund Freud*

The moot question in this controversy was : how could some parts of the self or personality get so dissociated or separated that one part could hypnotize the other? This question baffled many French physicians dealing with mental disorders, and the answer was provided by the brilliant Viennese doctor Sigmund Freud (1856-1939). He had specialized in medicine and neurology and had become interested in hysteria and went to Paris to study under Charcot. While studying it occurred to him that the inner conflict underlying hysteria was sexual in nature. Freud used the term sex in a very broad sense to mean the general motive power behind all intimate relations. His theory was that sex drives being frustrated by society are forced into the unconscious part of the self and from there they enter conscious life and cause mental disorders. Abnormal behaviour is just such unconscious drives appearing in a disguised form. Thus Freud could explain how one part of the self could induce the other to develop through hypnosis symptoms of hysteria and through hypnosis the hidden suppressed drives could be uncovered and hysteria again cured.

In collaboration with Joseph Breuer he developed a technique by which he let patients, mostly women suffering from hysteria, freely talk themselves out while in a hypnotic state. In this free talk they would reveal what had oppressed them, showed strong emotion and felt quite relieved when they woke up from the hypnotic state. Because in this method patients discharged their strong emotions and frustrated drives, it was known as the "cathartic method".

This helped Freud to develop his theory of the "unconscious" and the important role played by unconscious drives and wishes. These drives and wishes were revealed through free talk under hypnosis.

Soon Freud dispensed with hypnosis and let the patient



talk at random and freely, saying whatever came into his mind at the moment. This method was called that of *free association* and the patient revealed the innermost thoughts and wishes which had been forced into the unconscious and forgotten. What the patient said was analysed and interpreted and the conclusions were used to help the patient to gain insight into his behaviour. It was believed that the patient was cured when he realized the underlying causes of his abnormal behaviour and made healthy adjustments. This method is called *psychoanalysis*. We shall be dealing with it in detail later.

Freud's contribution to psychopathology is the most outstanding and created a revolution in the study of man. His main ideas may be summed up below :

1. He uncovered the dynamic role of unconscious processes in determining behaviour, emphasized the importance of early childhood experiences in adjustments and maladjustments of personality and pointed out the importance of sexual factors in mental illness.
2. He discovered the method of free association and psychoanalysis in knowing the conscious and unconscious factors in mental life and behaviour.
3. The principles of normal and abnormal behaviour are the same and the abnormal behaviour is only an exaggeration of the normal behaviour. Thus the mystery of abnormal behaviour was removed.
4. Through psychoanalysis he provided psychological treatment of mental illness. The aim of psychotherapy is to reconstruct human personality.
5. He laid stress on an integrated approach to the understanding of personality. We should know biological, social and psychological factors in the development and working of personality to get fully acquainted with the inner conflicts and frustrations arising out of psychological and biological motives on the one hand and social demands on the other. Man was considered as an integrated system of all these factors,



Freud's important works are listed in the bibliography at the end of the book.

### *Adler and Jung*

Two of Freud's followers, Alfred Adler and Carl Jung disagreed with him and left him in 1911.

Adler developed the school of *Individual Psychology* which holds that man's basic motive is not sex but a desire to belong and have status in his group, to gain superiority and power. Early life is full of defeats and failures and these give us a feeling of inferiority and inadequacy. So in later life we are forever trying to make up, to compensate and develop a will to power. When it is opposed we develop an inferiority complex and continue to seek power and superiority. If this compensation is sought in improper unsocial activities the individual develops abnormal behaviour. Psychoneurotic behaviour is not caused by the suppression of sex impulses but by the frustration of desires for self-assertion and self-esteem. According to Adler it is necessary to know the style of life of every individual before he can be treated for his mental disorders. What was his position in the family, what handicaps and deprivations he suffered in his early days and the like are revealed to him so that he may understand the nature and source of his inferiorities and make readjustments accordingly.

Jung formulated "*analytical psychology*" and argued that man is not motivated by sex or mastery. Life energy has no clear-cut forms. It may at one time seek sensual pleasure and at another time strive for superiority, artistic creation, play and other activities. There are personality types, the *extrovert* whose interests lie outside the self and who is a good mixer socially and the *introvert* whose life is inward, thoughtful and self-centred and who seeks power and prestige. He emphasized the *racial unconscious*, in which in addition to personal memories there are "racial" memories established through thousands of years and inherited in the brain structure through thousands of years of existence. It is because of such "collective memories" that folklore and mores of diverse cultures in the world are found to be similar. In psychiatry Jung made use of

free association and dream analysis. He tried to bring conscious-unconscious life together and to study both the past and present of the individual.

### *Otto Rank*

Otto Rank, an Austrian, observed that severe attacks of anxiety tend to be accompanied by physiological features very similar to those accompanying the process of birth and put forward the theory that all neurosis originates in the trauma of birth. The birth trauma, the essence of which is separation from the mother, produces a large amount of anxiety in the individual and this is aroused and intensified by later experiences of separation like weaning or separation from dear and near ones. The basic and universal source of anxiety takes two forms in the life of an individual, the life fear and the death fear. The life fear is the anxiety which one feels when his creative abilities make him assert himself and separate him from close relationships. The death fear is the fear of losing one's individuality, of being swallowed by the mass of society. This pushes him into a life-long dilemma of following the standards of society and creating his own standards. The basic problem of psychotherapy is to resolve the patient's separation anxiety.

### *The British Schools*

During the First World War rapid progress was made in the treatment of cases of neuroses by purely psychological means and Freudian concepts. With the publication in English of Freud's *General Introduction to Psychoanalysis* in 1920 and the appearance of Bernard Hart's little book *Psychology of Insanity* interest in psychoanalysis increased in both England and America. The war pushed a number of eminent psychologists off Europe to Britain, namely, Wilhelm Stekel, Freud himself, his daughter Anna Freud, and Melanie Klein. Two psychologists H. R. Rivers and I. D. Suttie modified Freudian psychology to considerable extent. They wanted psychological treatment of mental disorders to be active rather than passive, brief rather than prolonged and respectful toward the individual's moral and religious beliefs. Freud considered society repressive but Rivers held that it only inhibited the individual and induced him to use his higher powers.



Suttie emphasized the role of love against Freud's stress on sex. The mother-child relationship is seen not in the Freudian light of sensual gratification of the child which may at a later stage give rise to love for mother, but as presenting the child's need for company. Suttie held that cultural factors influence the child at all stages.

Anna Freud applied psychoanalytic techniques on children. She accepts the orthodox Freudian approach that the important drives are the sexual ones but holds that although the unconscious and the instinctual factors are of great importance, environmental factors cannot be ignored. For one thing the parents' attitude toward the child is very vital and to a considerable extent the pattern of child's problems changes with the changing environment. With the methods of Anna Freud children three years and above may be analysed and the method will depend on their age. The co-operation of parents is sought, both in making the child visit the analyst regularly and in giving information and reporting on progress.

Melanie Klein also accepts the orthodox views of Freud but holds that environment is much less important and that the important drives are aggressive. She treated children as young as two years old and her method of treatment is centred round the phantasy life of the child as revealed in play. The cooperation of parents is not sought because their reports are not likely to be correct and Melanie Klein attaches no importance to the reality situation.

### *The psychosomatic approach*

Psychological factors like loss of fortune, the death of a loved one or disappointment in love was quite naturally accepted by physicians as causing illness but the nineteenth century pathologist held that without organic defect no disease could exist. It was the work of Freud, Janet and Kraepelin, which showed that disorders could be psychologically produced and that even organic diseases could have psychological causes. Still popular thought looked upon this psychosomatic approach with distrust.

Georg Groddeck (1866-1934) held that it was "It" the psyche which decides when an individual should be born and when he



should fall ill. Such a view may look absurd but it is quite pertinent to ask "Why did you allow yourself to be injured?" Unconscious motives do work and lead to disease and injury.

Franz Alexander of Chicago combined physiological and psychological viewpoints. He compares the life of an individual with the life of a nation, both are ruled by conditions of war and peace. War calls for emergency reactions and peace for rest and relaxation. Similarly the organism has faster heart beats, dilation of pupils, pallor, inhibition of gastric activity and the like when the individual is going to meet a war situation that is, an emergency; when resting heart beats are slow, digestion is normal, the pupils are contracted and the like. Too many emergencies lead to hypertension and too much rest to dyspepsia. This is the organic basis of psychosomatic disorders.

Dr. J. L. Halliday is concerned with the problem of psychological and psychosomatic disease as a community phenomenon, and Wilhelm Reich studied the influence of social and political factors on character formation and tried to show that all neuroses have their roots in character, that is, in the adjustments which the individual has made to his instincts and the external world.

Psychosomatic approach had difficulties because in the traditional medicine the dualism of body and mind was very firmly rooted and it was only when the individual began to be considered as both body and mind that the new approach gained acceptance.

Before we end this short summary of developments in abnormal psychology we must consider a few names whose contribution to modern abnormal psychology has been significant. They are Karen Horney, Erich Fromm and H. S. Sullivan.

*Karen Horney, Erich Fromm and H. S. Sullivan*

A German psychologist, Karen Horney migrated to America and broke away from the Freudian school. She stressed the part played by social factors in neuroses and challenged the biological assumptions of Freud. Her works are extremely relevant in the industrialized society of America. She blames neuroses upon the contradictions of contemporary life in America ;



conflicts are ready-made by the American way of life. There exists a contradiction between competition and success on the one hand and brotherly love on the other, between the stimulation of needs by advertising and the inability of the individual to satisfy them; between the assertion that the individual is free, and his increasing limitation by the environment. All these factors result psychologically in the individual's feeling that he is isolated and helpless.

Fromm too stressed the importance of social and cultural factors in causing neurosis. Human behaviour cannot be explained purely in terms of the satisfaction or frustration of biological drives because the social process generates new needs which may even be more powerful than the original biological ones, but modern industrialized society lacks any universal frame of orientation and devotion and the individual is unable to impose a rational order upon this universe and society. Man tries to relate himself to society and solve this problem through four types of psychic mechanisms; moral masochism, sadism, destructiveness and automation conformity. These are ways of escaping from the intolerable feelings of helplessness and aloneness.

Sullivan too holds that the individual is able to develop his true self only through cultural factors and all attempts to break away from culture produce anxiety. His account of anxiety makes use of psychosomatic concepts. The satisfaction of bodily needs reduces tension. The pursuits relating to security are cultural in nature and social frustrations of interpersonal relationships are of particular importance in personality genesis.

### *Conclusion*

Today abnormal psychology and psychiatry has made rapid advances and the study and treatment of mental disorders is being undertaken by all civilized countries. It is difficult to review the recent advances in psychiatry in this elementary book for undergraduate students but even then the chapters that follow will give a fairly detailed account of some of the important developments. The aim of the present chapter was only to outline the way abnormal psychology grew and developed through the ages and particularly in the last two centuries or so.

## QUESTIONS

1. All science began with magic and reached systematic knowledge through religion. Discuss this statement with reference to abnormal psychology.
2. Compare the ancient conception of mental abnormality with the modern and discuss some of the important trends in the treatment of mental patients.
3. Discuss the psychogenic and somatogenic viewpoints in the growth of abnormal psychology.
4. What do you understand by psychogenic and psychosomatic approaches in psychopathology? Illustrate your answer by examples.
5. Discuss the main points in the Freudian approach and show how various psychopathologists differed from him.
6. Write short notes on the contribution of the following to abnormal psychology :  
Adler, Anna Freud, Melanie Klein, Erich Fromm, Karen Horney.
7. Explain how hypnosis and hysteria are related and how the one led to the other.
8. Outline the growth of psychogenic approach in the study and treatment of abnormal behaviour. How did the study of hypnosis and hysteria help it?



## Dynamics of Behaviour

All behaviour arises in needs. The individual acts when he lacks something or when his organic system is deficient in something. When a need is felt there is tension and dissatisfaction and the individual is compelled to act. The impetus which needs give to the individual to act is called a *drive*. A hungry individual is driven to seek food, a lonely person is driven to seek company. Every drive has a goal or an end which imparts a new energy to behaviour. The term *motive* includes a state of drive and a direction of behaviour toward some goal. In common usage it is difficult to distinguish between needs, drives, urges or motives and many psychologists use the terms interchangeably. Others accept a distinction. In this chapter we shall deal with the sources of human behaviour, the common patterns of behaviour and how people behave to adjust themselves to inner and outer needs. This will involve a detailed study of the several types of needs and motives and how they are modified and influenced by experience and forces of social environment.

*Drives and motives*

Drives are always related to some suitable purpose which they serve. They change and vary but they persist, they tend to satisfy a need under varied conditions. But needs and drives are not the same. The hunger drive is related to the need for food, but need means that something is necessary for a particular purpose. Food is necessary for a human being because without it he cannot hope to survive. But we are all familiar with patients or hunger-strikers who need food but do not desire to seek it. In their case the need does not lead to drive. Thus it is necessary to distinguish between need and drive.

Every drive is accompanied by a specific feeling. This feeling tone is unpleasant when the need and drive is strong but becomes pleasant when it is satisfied. When the organism is in a state of drive the individual attends to some objects and

ignores others. A thirsty man attends only to drinks and not to foods. And a drive will lead to behaviour which in the past has satisfied our need.

A motive is what moves a person to activity. It is concerned with the "why" of behaviour and not with the "how" of it. Motives seek to explain behaviour and not describe it. It is not always possible to know motives because they are not observable and can only be inferred from behaviour. Many motives may be present at the same time and some people hide their motives deliberately. A motive is a complex phenomenon involving need, tension, drive, goal and result. Like drives motives are many and varied. They lead to activity in relation to environment. Those modes of activity which give satisfaction in reducing tension and meeting needs tend to be related and those which fail to do so are dropped. All behaviour is directed toward a goal and when the goal is achieved, the need, drive or motive is satisfied.

### *Physiological drives*

To survive the individual has to maintain physiological balance, to satisfy the organic needs of the body, to protect it from injury from outside and to indulge in activities favourable to reproduction. To live the individual needs food, water, air, rest or sleep, elimination of waste products, and even temperature. When all these conditions are adequately satisfied the organism is in a state of balance or equilibrium which is called *homeostasis*. Often the child asks for definite foods or even eats soft earth or lime scratched from the wall; it is because his organic system needs these substances to keep up the equilibrium. In cold water the blood rushes toward the skin to keep it warm and in hot water it rushes inside to keep it cool. All these are homeostatic processes, activities to maintain the balance of the body. When the balance is upset there is tension and restlessness, the individual is irritated and disturbed, and he is compelled to act to restore the balance.

We know what it is to feel hunger. In acute hunger there is vigorous contraction of the muscles of the stomach. The person feels extremely restless and disturbed and strives hard to secure



food. When food has been eaten the internal biochemical equilibrium or homeostasis is restored and the person is satisfied and content.

We feel thirsty when the water content of the body falls. Our lips go dry and our throat is parched ; there is no saliva in the mouth. After drinking all these symptoms are removed, the internal balance is restored and the person is content.

In intensely cold weather we shiver and rush to a warm place or put on heavy clothes to make ourselves warm. In very hot weather there is much perspiration, the person feels lazy and exhausted and there is loss of appetite.

Sleep provides for physical and mental relaxation and without it we are disturbed both physically and mentally. Complete denial of sleep for some days may kill a person. We need sleep even when we are not tired and a long period of habitual sleeping hours makes us sleepy when the time to go to bed arrives. When people are deprived of sleep for two or three days they become irritable and emotionally unstable, they may have headaches and feel mentally confused and they may suffer from hallucinations and eye troubles. On an average a person can remain wakeful for 60 hours at the utmost and even then symptoms noted above start appearing.

Our need for air is equally urgent. We are not generally aware of it because we get it without much effort but if and when we are deprived of it even for a short time there is a risk of suffocation. Air is plentiful and few of us get into situations in which there is risk of suffocating, but there is no doubt that it is a vital need.

Sex and parental drives are no less vital and urgent and how much crime and anti-social behaviour is associated with sex shows how urgent and vital is this need. The sex urge plays a more pervasive role in life and thought, in fact its role in determining the pattern of behaviour and personality is so crucial that abnormal psychologists trace a number of mental disorders to its suppression and perversion. We shall deal with it in detail in a separate chapter later. The need for children is not less important and barren mothers and childless homes are a social problem only small communities can realize.

The need for activity, for searching and exploring our immediate environment, for understanding and controlling forces of nature, has driven man to build up this civilization with its sciences and technology. Children ask questions to satisfy their curiosity, break toys to find out what is inside and run away from home to satisfy their wander lust. Grown-up men go to the poles and the Himalayas in search of new knowledge.

Man also wishes to control his outer environment and his inner organic condition. He may ignore hunger, restrain his sex urge or deny himself opportunities for activity. He exercises voluntary control over his needs and drives.

### *Psychological motives*

Physiological needs are generally fulfilled and provided for in any civilized community, and they are very rarely the cause of emotional and mental disturbance except for sex. Of much greater importance to man's health, happy adjustment, efficiency and happiness are the psychological drives. These motives or wishes as modern abnormal psychologists prefer to call them have been an important subject of study and inquiry in all times but recently psychologists have taken pains to list and classify them, stressing the more important ones for closer study, and bringing out their range and role in life and thought. There is nothing like agreement as to the important motives but we may select those basic motives for detailed study on which there is general agreement and which are very vital.

*Security*: The desire to feel secure and safe is universal. Pain, want, discomfort and loneliness make us feel unhappy and so does the fear or even thought of these things. To *feel* safe is even more important than to *be* safe.

There is more than one kind of security. Physical security means that we are confident about the fulfilment of our bodily needs, getting food and shelter, protection from pain, injury and disease, and shelter in too cold and too hot weather. Economic security means that we have enough money and material to buy our needs and avoid want or loss. Psychological security means that our adjustments with things and people around us are healthy, happy and harmonious and we are free from



anxiety and worry. It is obvious that these types of security are related to each other. Modern emphasis on material goods makes people earn more and more to feel safe and secure.

The desire for security is universal. Young children cling to their mother's breast when in pain or danger and feel anxious in her absence. Orphans continue to feel insecure all their lives. Grown-up children seek the company of friends and are eager to be accepted by other groups. Primitive people cling to tribes and civilized people join clubs, trade unions and associations, they pay taxes and large amounts to insure against death, loss of property through fire and theft, they work hard to train and qualify for a job, to feel safe and secure. Many people resent change and reform in society because they feel safe in old ways, customs and traditions. Any kind of loss, of health, status, prestige, affection or property makes us feel insecure. People follow a strong dominant leader as he promises security.

*Affection* : We all wish to love and be loved, to belong to others and be tied to them by relations of affection. Giving and receiving affection in the family, parents and children feel that they are liked and wanted for themselves. All people seek companionship with others, they need a partner, a friend, a lover, a husband or wife because they need to be liked, loved, wanted, desired and missed ; to feel accepted, welcomed and approved, to be needed and of importance to others.

*Mastery* : The desire for mastery is the desire for recognition, achievement, mastery, popularity or superiority. Everyone is keen that others should notice and praise him, should accept him as an equal or even a superior person. He wants to overcome all thwarting obstacles and to be counted among the prominent and the dominant. There are many honours in society to which all people aspire and the mention of our name in *Who's Who* pleases us. People have day-dreams of their greatness and no individual is free from such a motive.

*Self-esteem* : In all communities people are keen to defend their pride, to keep up their self-respect, to save their face and to maintain their status, and their behaviour is motivated by their great eagerness to live up to their own standards of honour and dignity. We may call it his ego or his sentiment of self-regard

but everybody is very anxious that others should think and speak well of him. Many make heavy sacrifices to save their honour and undergo serious hardships to keep up their prestige.

*Self-expression* : Every man and woman feels an urge to do particular things and is satisfied only when he or she is able to get suitable opportunities for it. The child feels like pulling the tail of his sister and cannot suppress that desire. Many grown-up people even in very lucrative positions want to change their jobs because they feel that they are not getting suitable opportunities to do what they can do best or express their talents adequately. It is often difficult to find out and judge these motives but there is no doubt that they are there and are the highest needs of man.

*New experience* : The desire for new experience and adventure is very common. All human beings get bored with things and experiences which are repeated again and again. The sweetest songs and the most delicious dishes become dull and drab when they are repeated again and again. Man is continually seeking new ventures and new fields of work. Explorers and travellers, scientists and engineers, businessmen and statesmen are always seeking and trying new things, getting out of routine and the rut and chalking out new ways. It is such people who have enriched human life and culture.

*Aggressiveness* : Man is aggressive and hostile when he is thwarted and obstructed. Psychoanalysts say that man has both constructive and destructive urges and aggressiveness is another way of destroying things. People take intense interest in fires, accidents, murder stories and horror movies and it is attributed to their urge to break and destroy. But most psychologists consider aggressiveness as a reaction to frustration and may be a part of other motives too when they are not allowed to work and fulfil needs.

*Social motives* : Man is essentially a social being and some of his greatest pleasures and achievements are had in a social setting. One of the severest punishments which we can give to man is to isolate him from society and company as is done in solitary confinement in a jail. Clubs and other meeting places are popular because they satisfy man's urge to mix and converse with other people.



Motives are many and varied. What motives are more powerful depends on personal experience, social environment and the culture pattern in which a man lives? There is no method of measuring the intensity and strength of motives. Often there is more than one motive operating in any behaviour. A person is getting married because he wants a companion to share his life and work, has to gratify his sex urge and raise a family, wants a wife to run his home and release him from petty tasks, is planning to get a large dowry, to mix in social circles, to rise in social status and the like. Another invites people to dinner because he wants to return their hospitality, for his prestige, for material gain from persons whom he is inviting, for displaying his new dinner set, for establishing himself as a man of taste and culture, to introduce his new wife to his friends and the like. So most often any type of behaviour has mixed motives. Very often we sacrifice one important motive for another. One may sacrifice his affection for security or take risks for his near and dear ones. Even then in the lives of some of us one dominant motive can be observed. One is running after money, another is keen to gain social prominence, and still another seeks only love and affection. Differences of motives among individuals are very large and often it is very difficult to find out the motives of other people from what they say or do.

#### *Other sources of motivation*

Our *emotions* are prime movers of behaviour and their power to function as motives is readily recognized. Anger, fear, anxiety and hatred also produce tension to remove which the individual is moved to action. In anger we try to fight against the cause of anger, in fear to run away from it and in hatred to destroy it. Thus emotions too have goals like other motives. Emotions persist till the goal is achieved.

In every age and society there are certain *ideas* and *ideals* which direct the behaviour of people and act as strong motives. "Obey your parents", "Do not steal", justice, honesty, social service and the like prompt people to behave in a definite manner. Ideas of cleanliness direct our behaviour today as superstitions influenced our behaviour in olden times.

Some behaviour is due to urges which are largely inherited and inborn. They function as strong drives to action. *Instincts* make us do things for self-preservation and for the perpetuation of the race. We collect things, we are curious to know the strange and unfamiliar objects, we look after our children, and the like is instinctive behaviour. Instincts are implanted in the species by nature to serve the ends of survival.

A good part of our behaviour can be traced to *habits* which we have acquired in the course of our past experience. A Hindu takes off his shoes before entering a kitchen, and an Englishman eats with knife and fork, a priest raises his hand to say grace and the like. Such behaviour is due to habits formed in life. Often people are not conscious of their habitual behaviour. If we consider bad habits like smoking and drinking we will know the great impelling force of habits in life and behaviour. Habits as motives are persistent and demand certain kinds of activity to continue.

To sum up : motives are springs of behaviour, they are rooted in basic needs and drives, and they have goals and make behaviour purposive.

Some motives are unconscious and we shall deal with them in detail later as the concept of the unconscious is very important in abnormal psychology.

#### *Over-development of motives*

Motives grow and develop as a result of the interaction of the individual with his environment. But it may so happen that environmental influences repeatedly work in favour of one motive to the exclusion of others. When this happens again and again the individual becomes unduly sensitive to those influences which arouse that particular motive, and such influences acquire exaggerated value in the eyes of the individual. This is over-development of motives. If a child is repeatedly bantered and irritated so that he loses his temper every hour to the amusement of members of his family he becomes so sensitive to things and people around himself that the slightest provocation rouses his anger. How timid and cowardly those children become who are frightened by adults every now and then.



Even the most harmless situations rouse their fear and anything strange, new and unfamiliar gives them fear. Children brought up in families engaged in business and making money in every venture they undertake develop an abnormally exaggerated acquisitive impulse. They grab and snatch, and whatever they can gain by fair or foul means they do not hesitate to acquire. Their acquisitive and possessive motive has been over-developed. Similarly doting parents help the over-development of affection motive in their children so that the latter develop affection with all those with whom they come in contact. They become too attached to their parents, brothers or sisters ; later they may develop strong affection for their friends and wives which may interfere with their normal trait of self-reliance and independence. Such people may develop neurotic symptoms if they later try to reduce the intensity of these motives. In fact looking around us we will find that a good many of our colleagues and friends have some exaggerated or over-developed motive which is revealed in all that they say and do. Over-development of motives accounts for a large amount of simple abnormality.

#### *Under-development of motives*

Similarly some motives may not be fully developed. Some people are very careless about their possessions and never realize that they may have to face embarrassment. Their motive for economic security is very weak. They either do not care to earn or extravagantly give away what they have. In some families too much stress is laid on personal achievement and all sorts of dreams are built for the young ones as a result of which the young ones grow into self-seeking ambitious individuals. They strive hard to rise above and become leaders in their field of work, but with no desire to think of others or to engage in any programme of social service. The over-development of some motives means the under-development of other motives. Too much sociality may involve lack of interest in one's own family or too much absorption in one's family may lead to neglect of public spirit and charity. Some people are abnormally self-effacing, others are abnormally interested in self-display. Thus over-development of motives goes hand in hand with their under-development, and abnormal behaviour is due to both. Normal growth and develop-

ment of children implies that all their main motives should be harmoniously developed and the personality should have a balance and many-sidedness ready to meet a large variety of social and physical environmental influences.

This shows that the various motives should be closely integrated so that man's behaviour expresses a balanced view of personality. As has already been stressed normal behaviour is inclined to the average, harmony of various traits, motives and elements of personality and behaviour.

### *The Unconscious*

The contents of the unconscious are completely forgotten and rejected mental activities and states. Just as unnecessary and useless things in a home are packed away in a lumber room, so activities, thoughts and wishes which are of no use or importance are stored away in the unconscious. Some moral concepts which individuals cannot employ or practise are also pushed into the unconscious. This view was held by philosophers and psychologists for a long time till Freud on the basis of his clinical experience put forward a scientific view of the unconscious. According to him the *pre-conscious* or the *sub-conscious* consists of those mental reactions which can be easily recalled and brought back to consciousness as the multiplication table, but there are others which cannot be recalled in the ordinary manner and lie deeper so that special techniques have to be devised and used in unearthing them. They are not open to simple introspection but can be known through the new method of psychoanalysis which Freud devised. This is the proper field of the *unconscious*. Freud held that the unconscious is a powerful dynamic force for it is a storehouse not only of useless and unnecessary activities but of those which have a powerful influence on our behaviour and personality. What are the characteristics of this unconscious, how does it develop and express itself, are questions we should answer after we have given proofs of its existence.

What evidence have we of the power of the unconscious? Freud has dealt with the subject in detail. All of us have dreams and though our consciousness is not working yet we enjoy our dreams. Now the question arises how do we experience such dream processes? The answer cannot be given on the basis of conscious



experience. In dreams we experience many things which are bizarre and lacking in sense, inconsistent and absurd. Psychoanalysts find meanings in such dreams and they bring out such meanings through the method of free association. The concealed meaning of dreams is called the *latent content* of dreams. This latent content demonstrates the reality of the unconscious. Dreams express our thoughts and wishes which were repressed in the past because they were unpleasant, immoral or embarrassing. The moral conscience of the person worked as a censor and during sleep this censor is not working and the repressed wishes and thoughts appear in a disguised form in dreams. These wishes and thoughts are operating from the region of the unconscious.

As we shall see later there are a number of our acts which we are unable to explain why we did them. We forget to post letters to a certain person, we misplace keys, pens or other things of daily use, some people mop their face again and again or bite their nails, twitch their moustaches without being aware of it. They are surprised when their attention is drawn to these acts. Such acts are being induced by unconscious motives.

Many of us are unable to solve a problem of mathematics, lay it aside for the day and are able to solve it very readily the next day. It must be that unconscious effort to solve the problem was continuing.

Freud held that our unconscious mind is much more powerful than the conscious mind, that conscious behaviour is very often motivated unconsciously, and that some motives are of the unconscious. He likens behaviour to a stream, conscious activity is on the surface but the unconscious is below deep in the stream and determining and influencing all our important activities. The unconscious is made up of long forgotten memories, banished from consciousness because they were disagreeable, embarrassing and untoward, not in harmony with the accepted code of morals in society. These memories and wishes are *repressed*. The unconscious is a storehouse of repressed memories, wishes and thoughts. They cannot and do not enter into the field of consciousness.

This should not give the impression that the unconscious is static or inactive. In fact it is extremely dynamic and does not miss any opportunity to burst into the conscious region. The repressed wishes are always active and are responsible for many of our acts, involuntary and impulsive, which we cannot account for. We are ourselves surprised why we did them.

Freud speaks of three aspects or parts of mind, the *Id*, the *ego* and the *super-ego*. The *Id* is the most primitive stratum or level of mind which is made up of animal nature, instincts are located in the unconscious, and there is constant striving to satisfy the primitive animal instincts. The *Ego* is our rational self, it controls the *Id*'s animal urges and represses them into the unconscious, though some expression of the *Id*'s impulses is permitted. The *Super-Ego* resembles the human conscience and is made up of moral ideas. It works on the *Ego* to repress the *Id*'s socially reprehensible tendencies. There is thus a continual conflict between the *Super-ego* and the *Id* while the *Ego* tries to resolve this conflict. In a normal person this conflict is resolved successfully.

According to Freud every individual has a fundamental drive or source of energy called *libido*. He considers this drive as sexual but he gives a very broad meaning to sex. He holds that sex plays a very powerful role in life and behaviour, and all human striving in private and social life as all cordial and affectionate relations are based on sex. Sex is not mere lust or conjugal intercourse. After tracing the growth and development of sex in several stages Freud showed that sex urges are present at birth though there is a great difference in the sexual expression and behaviour of children and adults. Infants gratify their sex impulse by sucking, which later on in adult age they gratify by intercourse. Such behaviour in infants is unconscious. That is why it is argued that the unconscious is dominated by sex. This is amply demonstrated from the life of individuals. Everyone is eager to love certain people and in turn to be loved by them. They are hungry for love and if they do not succeed in love they gratify their love by fondling flowers, birds and animals. History is full of examples of wise and discerning men and women who defeated and



frustrated in love gratify it by bringing up orphans, by showing love for dogs and cats or by loving some kind of artistic work. Intimate affectionate relations between friends, brothers, parents and children are also inspired by sex. This sex is all important and dominates the unconscious. The unconscious is love hungry and there is ample evidence for it.

This sexuality is always at the childish level and sexual behaviour of adults is no less childish, there is no discrimination between proper and improper and all activity is free and spontaneous. This is exactly what happens at the conscious level, there is no restraint of moral or social standards and ideals and there is nothing logical or consistent. Emotions and impulses reign supreme. Therefore, it is not possible nor desirable that sex should be neglected in our study of human behaviour.

According to Freud all human behaviour is motivated by two main principles : the *pleasure-pain principle* and the *reality principle*. We all do that which gives us pleasure and avoid doing that which gives us pain. But soon we realize that an indiscriminate use of this principle in life lands us in trouble. A student feels pleasure in sleeping late hours and for long, but he soon realizes that this will not do as he will not be able to complete his work and studies and this will affect his health in an adverse manner. He wants to modify and change his behaviour in accordance with the needs and requirements of the situation. This is the reality principle in which controlling pleasure the individual follows etiquette, moral and social rules, and has to work for certain goals and demands of the situation. At the unconscious it is the principle of pleasure-pain which is supreme and every reaction is motivated by it and the reality is ignored.

Our conscious life is governed by the reality principle, it is constantly guided by the external world, but the unconscious is governed by the pleasure-pain principle and does not take any notice of the outside world. It would not be wrong to say that the unconscious is above time and place. Many people are afraid of climbing a mountain or a tower. Such violent irrational fear is *phobia*. They know that such a fear has no basis but they cannot help feeling afraid. Nor are they able to explain it because obviously its roots lie in the unconscious which they do not know.

In the unconscious wishes, memories and thoughts get intimately associated and fuse into each other. Thus they get strengthened or as psychoanalysts say *condensed*. This condensation is made easier by the absence of moral or logical restraints. Anything may mix and reinforce anything else. That is why repressed contents and the activities of the unconscious can always be expressed only in positive terms. There is no place for "no" in it. When there is no question of inconsistency or opposition the several contents of the unconscious are interchangeable. Freud has provided ample evidence to demonstrate the truth of his conclusions.

### *Freud's conception of mind*

To understand Freud's explanation of human behaviour and unconscious motivation it is very necessary that we know his conception of mind. He divides its work and nature in two ways. The first he calls *topographical* aspect of mind in which he distinguishes the pre-conscious or sub-conscious, conscious and unconscious levels or aspects of mind. We have already dealt with them. The conscious level is one of everyday living in which the 'here' and 'now' aspects are dominant. We attend to and perceive objects and people around us and react to them. The sub-conscious or the pre-conscious level consists of all those thoughts, memories and ideas which we have acquired and learned, which we have so to say put by, of which we are not always conscious and which can be recalled and reproduced whenever we need them. We are not always conscious of the rules of grammar and arithmetic but when a situation demands we recall and apply them. They seem to lie in the ante-chamber of consciousness waiting to be called in. They are in the sub-conscious or pre-conscious region. And then there is the unconscious region which we have already studied, a sort of lumber room or storehouse of repressed wishes, thoughts and memories which we recall only with the help of special methods and of which we are not even aware at any time of our life and experience.

He has also analysed mind to show its working. This he calls the *dynamic* approach. It should not be forgotten that Freud was almost the first psychologist to point out and



describe the dynamic character of mind. The dynamic nature of mind is divided into three levels, as has already been indicated, the Id, the Ego and the Super-ego. It is on the basis of this analysis that Freud tried to deal with abnormal behaviour and mental disorders. According to him conflicts between the different dynamic aspects of mind are at the root of all mental disorders, mental diseases and pathological behaviour. Conflicts go on at all levels and regions of the mind and it is the resolution of these conflicts which offers the key to the treatment of pathological behaviour and mental disorders. They also affect human personality and make it dynamic. Why do such conflicts arise and how they arise will be known after studying the characteristics of different aspects in detail which we do now.

*The Id :* It is the main reservoir of life and death instincts. It is primordial nature, the origin and root of psychological powers, the source of all energy. The Id is governed completely by the pleasure-pain principle and all its aggressive efforts are regulated by this principle. It has no idea of time or reality, of proper or improper. It is entirely impulsive, and seeks such goals as likes and dislikes, loves and hates determine. If the primitive wishes and desires of the Id were not controlled by reality and society man would never grow into an adult nor become civilized. It would act and behave only to seek pleasure and avoid pain. He would be forever at the level of an animal or child. At birth and for some time after the child is entirely at the level of the Id, and it is only gradually by coming in contact with reality and people outside that he learns to control and modify his behaviour in the light of conditions outside. Left to himself he would start eating as soon as food is presented. This is what is dictated by the Id. But he waits till everybody is served and eats gradually with grace so that others do not object to or dislike his ways.

*The Ego :* Freud calls it self-conscious intelligence. At this level the individual is aware of what is going on around him, and the Ego is closely related to the surrounding world. It takes notice of what takes place in the outside world and is built and developed on the basis of perception. The Ego too works on the pleasure-pain principle but behaviour is regulated

by the physical and social reality. Its strivings are consistent with the demands of the physical and social situations in which the individual lives and moves. It thus tries to adjust the urges of the Id to the physical and social reality. It has also a knowledge of the consequences of its behaviour and tries to strike a balance between the needs of the organism and the demands of the physical and social environment.

*The Super-Ego* : Freud calls it the Ego deal. It is through, and because of, the Super-ego that an individual is socialized and grows into a moral and social being. It is largely determined by social and cultural influences and, therefore, develops late in life when the individual is shaping and moulding into a ripe personality. It may be considered synonymous with the idea of conscience because the feelings of remorse and guilt arise in it. It is dominated by goals and ideals which we have set ourselves to achieve but which we seldom really achieve. The Super-ego is the moral aspect of human personality and is constantly controlling and checking the primitive urges of the Id. It is developed during our social and cultural development when an individual begins to learn the moral and social norms and behaviour as is approved of by his family, community and society at large. An individual passes by a bar where people are drinking wine and making merry. The Id urges him to go in, have a drink and make merry, the Ego tells him that he would soon be found out and cursed by his friends and acquaintances, but the Super-ego tells him that he should never do it at all because drinking is not good. Thus the urge of the Super-ego is the voice of the conscience.

If the Id is present at birth the Super-ego develops late in life and is added to human personality through social growth and education. It is just the opposite of the Id. But it is possible that the Id may pull the individual to the primitive animal level and the Super-ego may pull him to an artificial narrow level of rigid virtues and abnormal scrupulousness as many people take too strict a view of the conduct of others and of their own. It is the Ego which must keep a balance between these two extremes of too much primitiveness and too much moral puritanical ways. Both may produce pathological



personalities. If the Ego is strong the individual develops into a healthy balanced personality.

### *Unconscious motivation*

Unconscious motives are those of which we are not sure and which we do not recognize as causing our behaviour. Very often we explain our behaviour in terms of what we know but do not refer to hidden unconscious motives about which we do not know. A husband refuses to accompany his wife to the market for shopping because he is not feeling well, is busy or tired or has work to do. This is what he knows or says but the real reason may be that he feels neglected at every shop since it is his wife who does all the talking and bargaining or feels inferior as he does not know how to shop or bargain and he may be altogether unaware of it. Freud laid great stress that a man's behaviour cannot be understood fully unless we know his unconscious motives too. Slips of tongue or pen, forgetting of unpleasant experiences, involuntary movements, dreams and the like result from unconscious motivation. Such motives are often called unrecognized motives as we do not quite recognize them. These motives can be brought to light by the technique of *free-association* in which the subject is asked to relax and speak out whatever passes his mind on the presentation of key words. It is claimed that in this way he will reveal his unconscious motives. We shall deal with this method in detail in a subsequent chapter.

### *Behaviour as adjustment*

All behaviour is purposive, we act to achieve a goal and realize a purpose. These goals and purposes are provided by our needs, biological and psychological. If motives are simple and goals are easily achieved the individual may be described as well adjusted. But too often our needs, motives and ambitions are not easily met. Motives are complex, the individual does not understand them fully, they may be conflicting and opposing each other, often more than one motive compels action. There may be obstacles from the external environment to the fulfilment of needs and goals. The individual may have personal difficulties in pursuing certain goals and motives. Thus many factors may thwart the realization of our ambitions and goals.

In such conditions the individual is very much disturbed, under great stress and strain, and acts in a number of ways to remove those thwarting obstacles and difficulties. Or he may change his goal by seeking something else or lowering the goal so that it is attainable. He is adjusted when he is effective in meeting his needs and realizing his goals, and thus adapts himself to his environment. All behaviour is adjustment to environment in so far as the individual strives to meet his needs and fulfils his desires and ambitions in relation to his physical and social environment. When the goal is reached, the goal-directed behaviour ceases, and the individual is relaxed and released from tension.

But as has been pointed out above the individual is continually faced with adjustment problems of varying degrees of difficulty. We shall be dealing with adjustment problems and difficulties in the next chapter.

### *Economy in adjustment*

Behaviour is generally explained by the struggles between the Id, the Super-ego and the Ego at the conscious, pre-conscious and unconscious levels. But in all reactions made in the interest of adjustment the law of economy works, that is, the organism spends the minimum amount of energy. This is very essential considering that the organism will need greater fund of energy for more serious struggles, and for maintaining and promoting its welfare. This law of economy is fundamental to the process of adjustment. The individual meets the problems in the simplest possible manner according to his own estimate of the problem. He is always doing his best. He resolves his struggles and conflicts in a manner which appears most easy, simple and economical to him. May be that from an objective point of view it may not be so yet from his own point of view the course he adopts involves the least possible expenditure of energy.

### *Conflicting motives*

When motives clash that we can satisfy only one of them the individual is unable to decide which one to satisfy and which one to reject. He wants to satisfy his hunger but not at



the cost of his honour ; he does not want to beg food or accept it from others. He wants to feel secure in his job and clings to it, but at the same time the desire for adventure and new experiences pulls him to leave it. An educated girl hesitates between the prospect of marriage in a good family and that of a promising job in a good department. In a famine a father may be involved in a violent conflict between saving his life or that of his child. In times of crisis we all fall prey to inner conflicts and struggles of this type. These conflicts disturb our peace of mind and create tension and restlessness. Often such conflicts last a long time during which the individual vacillates from one course of action to another, sometimes he inclines to one side and sometimes to another. Unable to decide he feels upset and loses his mental balance. The deadlock may be resolved by weighing the comparative merits of the two courses of action but if that fails he may act impulsively following one line rather than the other just to escape the disturbed state of inaction. Or he may try to satisfy both the desires by half. If this state of conflict is prolonged and becomes permanent it may cause serious mental disorders and abnormalities of behaviour.

### *Frustrations*

The state of thwarting or blocking of desires is what we call frustration. The individual is unable to realize his goals and purposes and there is no motivated behaviour in respect of a particular need. Let us examine some of the general conditions which cause frustration. In the first place there are external obstacles and inner handicaps which may lead to frustration. An individual does not have the necessary health, strength, intelligence or other resources to accomplish what he has set his heart on. A young man may strongly desire to marry a rich and beautiful wife but may lack the necessary qualifications like looks, health, high position and income. He may dream of becoming a doctor without the means to qualify for it. Secondly, in social life there is so much competition that young people are not able to achieve what they so earnestly want to achieve. Success, eminence, popularity, new experiences and opportunities for rising higher in prosperity and recognition do not come to many. The few lucky ones get them and

others feel frustrated. In fact the modern competitive struggle for power, wealth and success is the greatest cause of frustration.

Some people feel frustrated because they set themselves too high goals. Since the nature of the goal determines the severity of difficulties highly ambitious persons often fall prey to deep frustrations. Only a few reach the top and the vast majority of people have to rest content with modest success. The number of young people who want to become film stars is legion but only a few succeed. Some of the failures take to some other profession and a good many only nurse their frustrations and feel bitter and tense, adding to their own unhappiness and infecting others with it.

Another important source of frustration in our country particularly is the hide-bound structure of the society which requires rigid conformity to rules and customs of the community in which one is born. How many young people feel frustrated that they cannot marry outside their caste or according to their choice. Members of the minority communities in both India and Pakistan feel very much frustrated. In the democratic secular conditions obtaining in India much of these frustrations have been resolved and many are able to share the opportunities offered to them. Again standards and rules of society do not allow us to gratify our desires as they arise. One cannot commit thefts or murders to become rich nor indulge in anti-social activities to win a good name.

Often social, economic and political disasters cause great frustration. Economic slump may cause financial loss, death of parents may deprive children of shelter, food and education or one may lose his job due to change of government. In some countries there is dearth of men or women and some people are never able to marry. Thus causes of frustrations are many and varied.

### *Effects of frustration*

Frustration varies in the extensiveness and intensity of its effects. Some frustrations are only slightly upsetting and others are so prolonged and violent that they destroy the mental balance and health of the person. It has already been shown that one may avoid frustration by changing his goals or reducing the scope of his ambitions. But frustrations of serious nature



when prolonged cause many types of maladjustments and must be overcome if one wants to live a life of poise and peace. It is important to recognize that all normal people endure a good amount of temporary frustrations as well as some lasting frustrations, and that such frustrations may serve to strengthen character. If we were to get all we wanted life would lose the spice of struggle and achievement. It is through overcoming obstacles and frustrations that we enjoy life and gain in mental stature.

The usual results of frustration are anger and hostility. When we are unable to meet our needs we become aggressive. When our car breaks down far away from town we may get angry, kick the car and curse the mechanic who handled it last. In all cases of frustration we feel like hitting back. People who have suffered too many frustrations and are unable to hit back become bitter, indulge in back-biting and criticism of everybody and everything, and develop indifference to others.

Again some people suppressed and frustrated break out in a violent manner in some other direction. Many small political groups unable to make themselves heard break out into acts of sabotage or express themselves bitterly against the State. A child unduly suppressed may revenge himself on somebody else. Or he may altogether withdraw from life and its activities. We shall deal with reactions to frustration in detail in the next chapter and also describe some of the common maladjustments which result from frustration.

### QUESTIONS

1. Distinguish between needs, drives and motives, and describe some of the important motives of human behaviour.
2. What is homeostasis? Discuss with examples its role in human behaviour.
3. Discuss the physiological and psychological motives.
4. Discuss the security needs of an individual and how society helps to fulfil them.

5. Describe the nature and importance of the unconscious in abnormal psychology.
6. Describe the nature of mind and personality according to Freud.
7. Discuss the topographical and dynamic analysis of mind as given by Freud.
8. What are the causes and effects of frustration? Give examples.
9. Explain what you understand by the following : Censor, condensation, conflict, economy in adjustment, need for affection.
10. Describe unconscious motivation. How do you know about its existence?



## Reactions to Frustration and Defence Mechanisms

It is important to know how people commonly react to serious frustrations and what serious maladjustments arise from them. Frustrations are highly uncomfortable and annoying experiences, they create intense tensions and the individual resorts to a large variety of activities to reduce such tension. The reactions may be normal and healthy such as making stronger and more vigorous effort to overcome the causes of frustrations or reducing our ambitions to what is readily achievable or changing the method of attack. Or they may be abnormal and pathological as are found in psychoneuroses and psychoses. We shall discuss here some of the milder forms of maladjustments resulting from frustration.

### *Inferiority feelings*

But sometimes even increased effort and changing or reducing goals does not avail and the individual feels helpless, inadequate and incapable of meeting the needs of the situation. Repeated failures and defeats produce what is called defeatism, lack of utter self-confidence and feelings of inferiority. The individual is in an emotionally disturbed state of mind which is called the *inferiority complex*. He feels he is unable to achieve his life goals because of his personal defects and inadequacies. He feels he is not as good as his fellows, he has uncomfortable feelings with regard to himself and his acceptability, he is afraid of social disapproval. He is extremely sensitive to criticism. Self-conscious, very suspicious and envious, always trying to run down others and analysing himself, he can be easily flattered and is inclined to worry too much.

Feelings of inferiority have no relation to actual ability or merit. Many people suffering from feelings of inferiority may be highly capable, in fact inferiority complex is much more common among individuals of high than of low ability. It is hard to believe that feelings of inferiority occur in people who compare very favourably with others and who have no

justifiable reason for feeling inferior. Then why do they feel inferior? Early childhood experiences gave them this feeling and then this feeling remained with them. Even though they know that they are better, more intelligent, healthy and likeable than others, the feeling persists.

Common sources of inferiority feelings are defects of personal appearance, some awkwardness in behaviour, some handicap in socio-economic status, some lack of material advantage and of necessary goods. Children from poor homes do not enter the home of the well-to-do and as a result come to feel inferior. Money and possessions have such an important place in our culture that people use every opportunity and occasion to make a display of them. Those who have behave snobbishly toward those who do not have and such differences breed feelings of inferiority. Again failure and defeat may destroy feelings of worth, and belittling, scolding and punishment may produce inferiority feelings among young people. In some homes parents are always finding faults in children, making fun of them or comparing them unfavourably with other children. These experiences make children feel that they are not adequate and capable.

People with inferiority feelings feel uncomfortable, lack the ability to meet people and deal effectively with them, try too hard to please others, may stay away from situations and people where they feel inferior and are unable to converse with confidence with superior people. They are very sensitive, to criticism and slight, they are very touchy and easily hurt. They are not agreeable to advice and are very hungry for praise and flattery. They are envious and jealous and often indulge in self-pity.

The best way to overcome feelings of inferiority is to try to know if you have such feelings and understand the causes of such feelings. You should emphasize your strong points and make the most of them. Also try to develop your competence and add to your ability. Making friends and working for their welfare and happiness goes a long way to correct feelings of inferiority. Active group participation produces feelings of equality and fellowship and avoiding speaking ill of others spreads



goodwill ; both these steps will help to remove feelings of inadequacy and inferiority.

### *Aggressive behaviour*

When frustrated strongly for a long time an individual instead of developing feelings of inferiority may develop aggressive and hostile approach to the source of his frustrations. He may seek revenge against a person who has obstructed him or try to destroy or injure things and organizations which have defeated his purpose. The intensity of the attack varies with the amount of frustration. Dismissed workers often work against the company and try to injure its property. Young people reprimanded frequently by their parents and teachers turn against them and defy or show disrespect indirectly if not directly. Sometimes frustrated people turn upon themselves and may commit suicide or do some injury to themselves. Frustrated women in India are known to beat their breasts or strike their heads against a wall. Mental depression, sulkiness, feelings of guilt and thoughts of running away from home and committing suicide are common effects of such aggressiveness against oneself. Many people committing suicide leave letters condemning persons who were responsible for their frustrations and defeats thus taking revenge on them because such letters almost always bring disgrace to them.

### *Mental mechanisms*

It is not always possible to resolve conflicts, frustrations or feelings of inferiority. There are many obstacles which one cannot overcome. A person with very weak eyes cannot join government service, a young woman cannot marry and have a home of her own because she has to earn and support her invalid mother, many people have very high goals but very ordinary ability and strive in vain to become a big officer or doctor. A person wants security but accidents like riots, fires or serious illness may deplete their resources and make them feel very insecure. Under these circumstances he may feel upset, tense and disturbed and continue to live with his conflicts, frustrations and inferiorities or he may seek relief by unconsciously making use of what are called *mental mechanisms*,

which may protect, give relief or offer an outlet for escape. For example, on meeting failure and defeat again and again one may try to avoid conflict and frustration by withdrawing from real life situations altogether and avoid trying anything or meeting people, or he may start indulging in day-dreams and gratify his unfulfilled desires in phantasy. These are methods of escape. They are also described as *defence mechanisms* because they help to defend and justify the dignity, esteem and prestige of the person. Defeats and failures lower and injure a person's esteem and embarrass him but by having recourse to mental mechanisms like day-dreaming or retreating from reality he is able to protect himself from such injuries to his self-esteem and ugly embarrassments. They are protective devices which give temporary relief.

Everyone finds it unpleasant to some degree to face troublesome problems and other disagreeable situations. Many people meet their difficulties square in the face courageously and try to solve them in a suitable manner. Others, however, try to escape from their difficulties by means of day-dreams, use of alcohol, illness, suppression, repression and the like. Such methods of running away from problems and difficulties of life are called *escape mechanisms*. But by whatever name we may call them mental mechanisms, defence mechanisms or escape mechanisms, they are unconscious devices to avoid, withdraw from or conceal our difficulties and problems and to put up a bright face on our handicaps and frustrations. They are used very frequently by common normal people but they become maladjustments and lead to harmful effects when people use them habitually and carry them to the extreme. Then they become symptoms of psychoneurotic or psychotic behaviour. We shall discuss them in detail in this chapter.

#### *Day-dreaming or phantasy*

This is very common. People who do not get along very well in their duties and with other people may day-dream excessively. This means that those who are not very well adjusted are more likely to get away from their real situation than those who succeed in their work and get along with people. Some who find life difficult and rough and are discouraged by failure and disappointments turn to a more pleasant world through day-



dreaming, reverie or phantasy. They create for themselves a world that gives them everything they want—leadership, distinction, love, strength, recognition or esteem.

Almost all individuals indulge in day-dreams at one time or the other. Several studies made reveal that adolescents are more given to day-dreaming and next come children, old people and then adults. Day-dreams show how frustrated and disappointed we are and they reflect our wishes and hopes.

In a day-dream the individual himself is usually the hero, the central character. He may be the conquering hero wishing and aspiring to all the glory of leading a team or a regiment, of making a brilliant speech or impressing audiences with his game. Or he may be a suffering hero dreaming of some disaster falling to him in order to gain revenge and sympathy. He may dream of his falling ill or even dying, and all the members of the family who now snub and belittle him regretting their behaviour and moaning for him. Or he may identify himself with some eminent character like Napoleon or Nehru and dream of what he would be doing in his place. Feeling himself in the role of another big person he may rehearse what he would accomplish in his place. People identify themselves with stars while watching a film show. Such identifications also occur when one is reading a story, drama or novel, and is more common among young boys and girls. Sometimes some of them are so carried away by such identifications that they carry some of their traits in actual life. Excessive interest in films and novels leads to young people gaining personal worth by trying to be something that one is not. When such people get back to the real world they move further away from it.

There is no doubt that some escape through dreams and identification is healthful, for it gives relief, relaxation and rest for a while. It is wholesome for an adolescent to take time off his studies and dream of adventure, romance and future success and prosperity, for old people to live again the younger days of vigour and strength, or for the statesman to visualize what bright future awaits his country if his policies and programmes are fulfilled. But one must not be away from reality for so long. There is no harm in dreaming of health,



wealth and happiness but it should not occur too frequently and for too long. Day-dreaming is an acceptable mode of adjustment so long as it does not interfere with normal life and its pursuits. The danger is that the dreamer may rest content in living in a make-believe world. But it should not be forgotten that all great men with outstanding achievement were dreamers, dreams are the wings that carry ideas to fruition, and most radical reforms, inventions, policies and programmes were made by people who dreamed a great deal. Day-dreaming is a maladjustment when any individual habitually accepts it as a substitute for action, striving and struggling against odds to accomplish anything.

### *Rationalization*

Every normal person needs a sense of worth, he wants to be considered worthy in his own eyes and in the eyes of his associates. When true reasons for our behaviour do not give us a sense of worth or self-importance and are not socially commendable we may offer such plausible but untrue reasons which enhance, save and protect our prestige, dignity and respect. This is *rationalization*. It is an unconsciously motivated act of giving reasonable but untrue excuses or 'explanations' of our behaviour. We do so to defend and justify our behaviour and to maintain our feeling of worth. It has several forms which are described here.

*Sour grapes*: This form of rationalization is illustrated by the famous fable of a fox unable to jump high enough to catch grapes turned away saying that "Grapes are sour". What is beyond reach is made out to be unworthy of achievement. Students scoring low marks may argue that examinations are not a true test of one's ability.

*Sweet lemon* is illustrated by a situation which is bitter and painful and is still regarded as sweet and satisfactory. A sweet response is made to a bitter situation. "It is really better to be poor because then we do not have to worry about money or property". A student who is rejected for hockey tour to different towns may say that he is very happy that he will be able to spend more time with his ailing parents or devote his time to study. There is some merit in converting



a bitter situation to a sweet one when we cannot improve it but it is not healthy when it is a substitute for honest efforts to do better.

*Face-saving* too is common. Young people rationalize their failure or poor score in the examination by arguing that they are not book-worms and are spending more time in learning better things which develop their intellect and health. They defend and excuse themselves by giving plausible but untrue reasons.

*Self-justification* is in evidence when we offer some high sounding excuse to justify what we have done. Countries go to war to defend their commerce, existence or prestige but proclaim that they are fighting for freedom and democracy. A student fights with another student and beats him but instead of admitting that he fought in anger he justifies it by claiming that his opponent was being a nuisance to others also.

Such explanations and excuses are offered after the act and the more strongly we defend our behaviour the greater seems to be the need for defending our esteem and importance.

The use of rationalization in the above examples shows that it has great value for adjustment and is very convenient in turning defects into assets. The best method of avoiding rationalization is to acknowledge our failures and defects and make up for them, to recognize our weaknesses and try to cure them. Rationalization is bad because it is more or less an attempt to deceive ourselves and others, and such deceptions create more maladjustments. One should think of positive solutions and then work for them.

### *Compensation*

In this defence mechanism an attempt is made to cover up weakness by emphasizing desirable trait or making up for frustration in one area by overgratification in another area. The weakness or frustration may be real or imagined. Compensation may be direct or indirect, desirable or undesirable. Direct compensation is implied in a person's vigorous striving to overcome his frustrations and failures and reach success in the field of his inferiority. Demosthenes overcame his stuttering to

become a great orator. Many cripples have built up vigorous health by careful dieting and exercise. But most compensations are indirect, there is an attempt to substitute for the defect or shortcoming in some way or to draw attention away from it. A physically unattractive girl may develop grace and sweet manners, a weak student may make up in games, a mediocre may put on showy clothes to pass for a dandy and attract attention away from his mediocrity to prominence in dress. Some people are doing good trade in making up people's defects. A short girl is made to look taller by adding to the height of her heels, by helping her to slim or making an unattractive face glamorous. Compensation is good and desirable when we compensate for our inadequacies and failures with virtues and strength. It is undesirable when we cover up our insufficiencies with unacceptable or useless behaviour.

Many a young student not able to make a mark in studies starts making trouble and acquiring a reputation for impertinence which he calls courage, for shouting back to teachers which he calls nerve, for bullying which he calls independence. The younger boys look up to him as a hero and he feels a certain pride in his reputation. A person who is unloved and frustrated may start eating too much or bragging excessively. Many people brag about their ancestors or their property, while others are always cutting down people to their size. In extreme cases people may indulge in anti-social behaviour to gain prominence or notoriety or develop some eccentricity to attract attention. Modern society is highly competitive and we are always being surpassed by others and most of us are seeking compensatory activities to boost our prestige. Putting on suits of the latest cut, having status equipment like a refrigerator or a car, keeping big dogs or going to the hills in summer are a few of the many reactions which people have to outshine their friends and neighbours. They are all compensatory reactions. They would be undesirable if they are accompanied by anxiety or become anti-social. Numerous examples of over-compensation may be cited. A man walks with a swagger, appears stiff, does not readily enter into conversation with others, speaks little and pretends loftiness of manner and living. May be he is making up for his inadequacy in social intercourse, in social training



and polite conversation. Another may talk of being very busy, of having a lot to do, of being worried by big people, of having many social engagements. He too is making up for lack of adequate achievement. Such undesirable compensations only help to add to our difficulties. We all have weak and strong points but instead of covering up weak points we should develop our strong points.

### *Identification*

*Identification* refers to the mechanism through which a person attempts to mould his own ego or self by believing that he is some other person. At the normal level hero-worship is common enough and children identify themselves with their parents as college students identify themselves with their favourite teacher or grown-up people identify themselves with certain club leaders and the causes they uphold. Superiors in all areas of life and work are imitated by inferiors, their mannerisms, gait, speech or dress may be copied. Society too judges a person from the various types of clubs and associations with which he is identified from time to time, and he too begins to evaluate himself in the light of such identifications. Most employees identify themselves with the company or office which they serve and derive prestige and dignity from them. They attribute to themselves some of the achievements and good qualities of the organization. We have already dealt with identifications made in day-dreams and how they yield feelings of worth and importance, of adequacy and even superiority. But some people identify themselves with the loser or the villain and would like to be classed as a gangster, desperado or burglar. Such negative identifications are due to guilt feelings or suppressions of unhealthy nature.

Generally people identify themselves with others of their kind. An athlete would identify himself with a superior athlete, a young speaker with a big orator, a girl with a film star or an overseer with a chief engineer. Of course, such identifications have to be consistent with the values the individual cherishes. Such identifications through day-dreaming enhance our Ego estimates, add to our self-importance and help us to get over our frustrations. But in the extreme form they are quite dan-

gerous. In lunatic asylums there are many inmates who firmly believe they are Napoleons, Nehrus or Krishan. Such identifications are made at the unconscious level and are due to repression. A young man may throw up his engagement because he comes to know that the professor he admires most did it in his younger days ; he derives strength from his example.

### *Retreat*

In retreat the individual reduces the tension of needs, frustration and anxiety by withdrawing altogether from the scene of action. He feels timid, passive and seclusive. Coleman calls it "emotional insulation" while Burnham calls it "pseudo feeble-mindedness". As a result of previous failures and disappointments the individual does not lower his aspirations but learns to restrict his interest in outside people and things. One important way of withdrawing from reality is to refuse to join any competitive activity. If they do not venture out into any adventure or activity they do not have to share any blame, punishment or failure. A good many shirkers of responsibility in administration are so unconsciously motivated. Even if some information is asked for they would reply "I don't know", "I can't say". They are not prepared to make any commitment, even of the harmless type, nor to take any risks. They avoid being emotionally involved in anything or person. The best course for persons is to share and join group activities and develop intimate relations with their fellowmen.

### *Projection*

In this defence mechanism an individual ascribes one's own thoughts, wishes, inhibitions and faults to other persons or objects in the environment. This may be analysed into two aspects of this defence mechanism : (1) attributing to others our own unacceptable impulses, desires and thoughts, (2) shifting the blame for our own shortcomings, mistakes and misdeeds to others. "I eat much more, it is in my blood, I am a Brahmin", "I could not get high marks in history because the teacher does not like me", "I was not selected for the job as I had no recommendation" and similar statements are often made to blame others for our defeats and failures, they are examples



of projection. If these excuses are not true they may be considered rationalizations and if they are transferred to other persons they are examples of projection. In a sense all projections may be considered as a type of rationalization. If a tennis player knocks the ball into the net and then looks at the racket to show that it was the fault of the racket, he is projecting his failure on the racket instead of admitting his failure. Most people in India today are blaming others for corruption, inefficiency and indifference to work, they may be indulging in projection. They may be trying to gain a feeling of superiority by pushing their shortcomings on to others. It is an unconscious attempt to show that we are superior to those whom we are blaming.

Young people fight but each one says and believes that the other hit him first. The Indian Government unable to handle the food situation blames it on the rising population, the business community blames the Government for all ills of their trade. Page calls it "externalizing of personal defects" to protect the ego from self-criticism. When an individual criticizes another for stupidity, dishonesty or selfishness he indirectly implies that he himself is free from it. Literary critics are victims of projection when they see in the work they comment upon the faults and foibles of which they themselves are guilty and in transferring them to authors they are able to gain their own self-esteem. People who indulge in back-biting are forever criticizing others for this very fault. A priest obsessed with sex and wicked thoughts is always seeing them in other people's behaviour. We unconsciously resort to projection to defend our own self-esteem.

### *Introjection*

Introjection is the opposite of projection. In the latter the person externalizes his thoughts and wishes and transfers them to persons or things outside, but in the former he internalizes and adopts other people's good points to boost and bolster his own ego. It is not identification in which the individual wants to be like another person. He incorporates in his ego what is of the outside environment, he believes he has the characteristics and abilities of others. In the psychotic

conditions of schizophrenia and other delusions the patient suffers from mistaken identity. When the lover says, "I shall always carry you in my heart" or the God-intoxicated person bursts forth, "Oh God you are sure to come to my help", he is internalizing what is outside his ego. In a way introjection is basic to all defence mechanisms as the individual unconsciously modifies his own self to suit the external environment, and begins to accept the values of others. The Negroes by their long stay have come to accept the class distinction between the white and the black races and consider themselves inferior as the rest of the population believes just as in India centuries old custom has made the Harijans believe with the rest of the caste Hindus that the Harijans are really inferior and lower than them. They had introjected or internalized the values of others. Such people seem to be working on the principle that what you cannot cure you must accept; if you cannot defeat your enemies you join them. Many Indians followed the British officers in their ways, manners and speech because they had internalized and adopted them as a part of their ego.

### *Negativism*

There are people who always say "no" whenever they are asked to join a game or picnic party. "I am not interested" or "I don't care" is the typical reply. Such attitude is *negativistic*. Generally it is the result of unfair and discriminatory treatment and the individual rebels against it by doing just the opposite of what he is asked to do. He refuses invitations and does not co-operate. "Keep off the grass", "Do not make noise" and the like warnings are just an invitation for such a negative person to do just what he is forbidden. He responds unfavourably to suggestions, refuses requests and does not respond positively to directions or instructions. He resents authority and does not work well in a subordinate position. Negativism is the act or characteristic of being unco-operative or tending to do just the opposite of what is desired.

Negativism is quite common among women and children, in fact in all those classes of people who are frequently ordered about and not given opportunities to do things according to their light. They rebel against pressure and this negativism



is an expression of their retaliation or rebellion against coercion and excessive control. Negativistic people expect to be asked a number of times before they accept an invitation. They get a feeling of worth or self-importance by refusing requests and invitations. Such people may end by being left out altogether.

Many people respond negatively because they lack the courage and confidence to respond positively, and feel inadequate and unsure. They are afraid of not succeeding in what they are asked to do ; so they refuse. In discussion and debate negative people take the opposite point of view and hold obstinately to their views. They are critical of every proposition, hostile to every new acquaintance. They are *anti* of all things and persons. Thus they shut out all friendship and new ideas.

Pampered self-centred children are prone to negativism. Often they throw up temper tantrums and lie on the floor crying. Such children on growing up become highly selfish and oppose everything in which they are not given a prominent part.

### *Displacement*

Displacement is the expression of emotion in a situation other than the one which aroused it. Emotions are shifted from a person or object which originally aroused them to another person or thing. A person rebuked in the office is unable to express his anger against the officer but takes it out on his family on reaching home. Displacement occurs when the direct expression of emotions is inhibited and, therefore, it is transferred to some neutral or unrelated object or person. A child who has been punished by his mother may break a toy or pinch his younger sister. Somebody just warns us on the road to be careful, it is a minor incident but it arouses emotions which continue and any other incident later in the day may trigger it off into a major outburst of feeling. It is common how our day is spoilt if we start our breakfast with a sulky mood, our emotions hang on to everything that comes our way. Subordinates often warn their colleagues to avoid meeting the boss on days when he is in a mad mood. This substitution of the

object of emotion arises from frustration and helps to add to our sense of importance and worth.

The emotions commonly displaced are those of anger, hate and fear partly because they are strong emotions and partly because their free expression is not socially approved. There is an Indian proverb that a person who falls from a horse curses the horseman. Many primitive people beat their breasts when they are helpless in expressing their hostility against their enemies. Self-torture and suicides are often cases of displaced aggression.

Displaced aggression and hostility are a common feature in authoritarian organization. When people are continually snubbed, rebuked, and punished they retaliate by expressing their temper on others below them. In every department there is some subordinate who is made a scapegoat for all things which go wrong. Scapegoating is very common and is an example of displacement. We blame student indiscipline for falling standards, rising population for food shortage and official corruption for laxity in social standards. By scapegoating we shift the responsibility of our own defeats and failures on others. Displacement as a defence mechanism takes place unconsciously.

### *Regression*

By regression we mean reversion to primitive or childish forms of expression or behaviour. It is a relapse into immature behaviour and the individual adopts behaviour patterns of previous stages. When a person habitually looks back to the days gone by and lives in the past he shows regression. Old people usually go back and excessively recall their past experiences, in young people there is a tendency to want to return to childhood days. When old people are no longer active and have not much to look forward to they are prone to look back to good old days. "People were more friendly, not so selfish and busy earning money" are typical statements of old people. Others return to childish ways of weeping when they are in trouble. They act the age of five or six and not their own age. The college student who in frustration refuses food or kicks and breaks things is regressing to childish years and behaviour.



*Reaction formation*

It is unusual but interesting that people develop conscious attitudes and behaviour patterns which are just the opposite of various repressed wishes and thoughts. The socially undesirable or unacceptable urge is altogether denied and disguised by the development of traits which are directly opposite to it. Many people are highly intolerant and extremely critical in a very disproportionate degree of some traits and attitudes of others when they themselves are guilty of those traits and attitudes. Highly corrupt, dishonest and loose people are often excessively hostile and vindictive against even slight corruption, dishonesty and looseness in others. The self-appointed reformers of public abuses may themselves be not free from them. Many people when they are excessively angry pose as extremely kind and humble people. The guilty person protests too much as Shakespeare remarked. Highly worried persons may adopt "Don't care" attitude to hide their worry and fears.

If we accept socially disapproved behaviour on our part it would lower our worth and importance and so we react in the opposite manner to conceal it and save our self-respect and importance. We are pure and noble and it is the other person who is involved in vices. Like other defence mechanisms reaction formation involves self-deception and instead of making for healthy adjustments may lead to exaggerated fears and worries and thus prevent effective and healthy adjustments.

*Escaping by illness*

Trying to get away from one's problems and duties by more or less unconsciously becoming ill is an escape mechanism that is not uncommon. It may be practised by a schoolboy who is unhappy with his lessons or examination, the housewife who dislikes the housework, and the soldier who is afraid of battle. When situations in which we are sure to meet failure and defeat are hard to avoid, illness real or feigned may be used as an escape. In some cases they actually fall ill, and hope they would be excused because nobody blames an ill person.

Illness may also be used for another reason. Some are not able to make a suitable place for themselves in life

by their own merit. They want more attention than they can get. So they resort to illness as a way of getting that attention. To be visited and inquired after enhances their sense of worth and importance. The sooner such people realize that such assumed illness is a very ineffective way of making adjustments to their problems the better for them and others.

### *Repression*

In this mechanism painful, dangerous or embarrassing thoughts and wishes are banished from consciousness. It is often called selective forgetting. When we have conflicts we cannot handle, unpleasant memories we cannot face, injuries we will not acknowledge, repression occurs. When they become too much for us, our unconscious may prevent them from entering into consciousness.

Repression is a basic mechanism. According to Freud when primitive and animal tendencies of man come into conflict with the conscience or moral ideas, they are pushed back into the unconscious. It is obvious that this phenomenon of repression is social. We have regulations, customs, traditions, laws and taboos in society and they make it necessary that a large amount of behaviour must be inhibited and repressed so that social disapproval is avoided. Some repression leads to behaviour socially approved, but when conflicts are violent repression may lead to some form of neurotic behaviour.

A distinction should be made between suppression and repression. When a person does not allow himself to think of a particular episode, it is *suppression*. This term is also used for the act of keeping information away from others. When unconscious activity prevents some memory, thought or wish from entering the conscious, we say there is *repression*. Suppression is conscious and voluntary while repression is involuntary and unconscious.

When I say that I will not think of my quarrel with my wife as I have to concentrate on my office work, I am suppressing this thought. When I put away the thought of hunger or thirst because I have some urgent work to do I am just trying to suppress my thoughts and wishes. Mohan enters the



house and his mother asks him if he would have some tea. He replies sharply and rushes to his room. After some time he comes out, takes tea and gradually opens out how he was disappointed that he had not been selected to play hockey against the other school. To begin with he was suppressing his disappointment and revealing his unhappiness he felt much better. It is the thoughts of unpleasant experiences we suppress because they cast unfavourable reflection on us, tend to lower our worth and injure our self-esteem. So in order to save our prestige we put them away and suppress them. Some suppression is very wholesome. We all must learn to keep away trivial irritations and disappointments from our mind, to solve our problems and difficulties and concentrate our mind on what is urgent and important. This kind of mental discipline is necessary for all those who wish to make the best use of their mind.

In repression that part of the situation which is most unacceptable to the Ego and Super-ego may be forced into the unconscious by the Ego. It occurs in a situation in which intense fear develops with regard to the consequences of carrying out some wish. It is frequent in childhood when the weak Ego of the child is unable to cope with some of the imagined or real consequences of his loves and hates. The memory of such wishes is practically lost because the person is not consciously disturbed by any spontaneous recall of those loves and hates. But even then repressed memories are not permanently forgotten. They are simply cast out of the conscious mind into the unconscious. They may burst into the conscious in a subtle and disguised form and thus disturb the individual's balance and poise. Highly emotional desires when repressed continue to smoulder in the unconscious, and as and when the individual's hold on himself and his environment is weak and loose, they may break out in disordered behaviour, and make him unhappy.

### *Sublimation*

To begin with the term sublimation was used to redirect sexual impulses and energy into other purposes such as writing poetry, taking part in sports, doing social service, or indulging

in artistic activity of some sort, but now it is used for directing and channelling frustrated impulses and urges into substitute activities. It is implied, of course, that the original urge or desire is not socially acceptable or approved and is now employed in activities which are. It is goal substitution. A girl rejected in marriage may take to such satisfying and socially commendable activities as nursing, teaching or doing social service. A woman denied her own children may take to serving in a nursery school where maternal affection finds play. Thus sublimation involves the use of general mental and bodily energy in constructive activities which reduce tension built up around frustrated desires, mostly sexual.

Sublimation helps to account for the eminent work of genius, social reformers and pioneers in any field of useful work. In them the unconscious conflict is resolved by "a flight into creative work".

### *Conclusion*

To sum up : our basic urges motivate all behaviour, they contribute to our personality structure, and conflicts lead to frustration and defences mechanisms. These mechanisms listed here may not be all the types of mechanisms employed by human beings. There may be more, but they are able to account for the behaviour which is unconsciously motivated and are uncovered by psychoanalysis.

### QUESTIONS

1. What is a mental mechanism? Why is it called defence mechanism? Give examples.
2. Explain repression and distinguish it from suppression by giving examples.
3. What is rationalization? Compare it with projection by giving examples.
4. Explain compensation with the help of examples from your own friends, and compare it with identification.



5. Distinguish between reaction-formation and negativism by giving examples.
6. Explain inferiority complex. How is it developed and what are its symptoms and remedies?
7. What are the advantages and disadvantages of day-dreaming?
8. Explain introjection and displacement by giving examples. What is sublimation?

## Sex : Its Development and Perversions

Sex is one of the most powerful drives and its influence on behaviour and personality is very important and crucial. In abnormal psychology the role of sex is greatly stressed in so far as it is considered to determine the nature and pattern of personality. Ordinarily people believe that sexual urges arise in youth or with the onset of puberty, but Freud used sex in a very general sense. According to him the sex impulse arises with the infant sucking at the breast of its mother and continues to grow and develop thereafter. It was in 1909 that he for the first time stressed the nature of psychosexual development as a phase in the general development of personality and pointed out the several types of sexual perversions. For Freud, the sex urge passes through five stages of development and in this chapter we shall study in detail these five stages as well as some of the important abnormalities and perversions connected with the sex drive.

### *The oral stages*

It is the earliest stage in sex development and begins with birth. The infant derives all types of sex pleasure from sucking at his mother's breast. At this stage breast-sucking is the main activity of the infant and when he does not get opportunities for this he enjoys sex by sucking his thumb. This stage of sucking has been called the first stage in sexual development. A little later he may get the same pleasure and satisfaction from the excitation of lips and mouth in sucking other objects. If his stomach is full he may suck other things. Along with sucking infants derive much pleasure from being rubbed at the sensitive parts of the body. Freud holds that such pleasure from rubbing leads to masturbation later on. Generally this oral stage of sexual development lasts for about eight months. But it does not mean that such aspects of sex development disappear altogether after this duration, they merge into the expressions of the next stage. It is



difficult to lay down any hard and fast period of time when one stage comes to an end and the other begins.

In the oral stage the infant seeks relief from tension by the oral act of sucking and he is not aware of any distinction between himself and his mother. Although he gets satisfaction from the activity of his own body yet he is not conscious of it. That is why abnormal psychologists have called this stage as one of *auto-erotic satisfaction*. The main characteristic of infantile sexuality is auto-eroticism or self-love, the sexual satisfaction is derived not from others but from himself. Secondly this sex feeling is derived from sucking and oral activities. Thirdly, the experience of sex pleasure is associated with such parts of the body which when rubbed yield lustful pleasure. Lips are highly sensitive and arousing them the infant feels such pleasure. Thus infantile sexuality does not involve excitation of the genitals. Later Freud and Abraham traced adult kissing to sexual activity involved in infantile sucking.

The second phase of the oral stage is characterized by biting through which the infant derives satisfaction and pleasure. This stage lasts from the age of eight months to eighteen months. With the beginning of biting sucking does not stop only biting is more predominant. The infant is more aggressive and aggressive activities throw the sex urges into background. According to psychoanalysts this stage is marked by ambivalence, the infant loves his mother but also wishes to be independent of her and both sucking and biting continue. It is at this stage that we have the first indication of *narcissism*, that is, he derives pleasure from his body, is aware of his body and begins to love his body. Many followers of Freud have dwelt at length on the characteristics of this stage, but the main features are sucking and biting, and biting is also associated with destroying and breaking things as a part of the sex urge.

### *The anal stage*

This is the second stage of psychosexual development which follows close on the oral stage. The sexual emotional interest is shifted from the mouth to the anus. This stage begins at about the age of six months and lasts till the age

of four. The infant experiences satisfaction in elimination and the Freudians believe that this satisfaction is akin to the satisfaction of the sex drive. Like the oral stage this too has two aspects, the expulsive and the retentive. The expulsive aspect lies in defecation and urinating and in both these activities the infant seeks to relieve himself of tension, and the mucous membrane in that part of the body is stimulated. Freudians believe that this stimulation and the resulting satisfaction is a form of sexual satisfaction which the infant derives from activities connected with elimination. Soon he learns that parents insist on elimination at a particular time and place and what is eliminated is considered unclean. He also begins to understand that the act of elimination is approved by parents, that it is very necessary and that it gives him relief from tension. Freudians hold that elimination promotes and enhances the infant's narcissism or self-love.

Freudians consider this stage to be very complex in which the infant alternates between the reality principle and the pleasure-pain principle. Acting on the former he eliminates when and where he is expected to and acting on the latter he pleases himself about it, often spoiling clothes and things. It is held that such behaviour is aggressive and helps to nurse his ego.

In the retentive phase he derives pleasure not from expulsion of the waste matter but from its retention. He begins to see that if expulsion is important so must be retention. Some of the Freudians believe that the infant expresses his self-assertion and aggression through retention. But cultural factors play an important role and in each culture training for elimination is different and so must be the effect of such training on the mind of the infant.

### *The phallic stage*

At the age of three or four the infant enters the phallic stage and his interest in his genitals increases. He frequently plays with them and masturbation is also present. Also the tendency to show off his genitals finds expression. What is called exhibitionism is found in this stage. The infant identifies himself with his genitals and these are more sensitive too.



Active pleasure seeking impulses are predominant, and he begins to be afraid of losing or injuring his genitals. The psychoanalysts have called this castration anxiety.

In this stage children come to realize differences in their genitals. Often there arises feelings of jealousy about their genital construction, girls may feel the absence of genitals. Differences between boys and girls are thought about and questions may be raised. Later such differences are recognized and accepted due to cultural influences. It is possible that such differences may produce feelings of inferiority among girls.

### *Oedipus complex*

It is in this phallic stage we have signs of the oedipus complex. In infantile sexuality love for the mother is the highest. Freudians believe that the child's affection for the mother has an unconscious sexual element. The father is an obstacle in his maternal affection and he is, therefore, unconsciously working for his removal. He takes his place in imagination. This is the oedipus complex. When the son loves his mother, hates his father and desires his death or the daughter loves her father, hates her mother and desires her removal, in psychoanalytic terminology it is called the *oedipus complex*. These are examples of *positive oedipus complex* but when the son loves his father and hates his mother or the daughter loves her mother and hates her father, it is the *negative oedipus complex*. The kind of oedipus complex depends on the experience of an individual. Generally the moral atmosphere prevailing in the family and their approach to sex influences the nature and kind of the oedipus complex which members will develop. Often they have certain experiences which shock them, the birth of a child in the family and witnessing untoward things being done by father or mother, and similar traumatic experiences influence oedipus complex of children. The socio-economic differences in family status also make a difference to the growth and development of oedipus complex among children. It is quite obvious that the nature of the complex in poorer families will be different from that in richer families. Differences in the patterns of culture and discipline prevailing in the family also influence it.

Similarly in the beginning the daughter loves her mother but in course of time on account of adverse experiences she begins to hate her. It may be that mother's affection is transferred to another new-born in the family or her affection is lost to her due to weaning.

### *The stage of latency*

From the age of five to seven the sex drive of the child remains suppressed due to fear of social consequences and he does not consciously take part in any talk about sex. This suppression is neither sudden nor complete. Education sublimates the sex urges and his energy is directed to learning, reading and writing. The child also acquires moral ideas and ideals of the family and the society to which he belongs and learns to behave according to social standards. The sex urge lies dormant in this stage, and satisfaction and pleasure is obtained through play activities, games and sports. If their parents try to show affection toward them by kissing them they are very much confused. At this stage they show no signs of any sex behaviour. Some psychoanalysts are of the view that even in this latency period some children do indulge in sex behaviour like masturbation which should be considered a regression to the earlier stage. Repression of sex in this stage is often the cause of unconscious mental conflict. Children are really very good at this age and often criticize the behaviour of their own parents.

At this stage the attitudes of love and affection toward the parents is replaced by that of devotion and respect. Ideas of hatred and hostility which were found in the early stage tend to disappear and there is greater good-will and friendliness. The child no longer believes his parents to be all powerful and to a large extent is influenced by his companions and classmates. Parents often complain they are neglected by their children, the latter respond more to their friends than their parents.

They have a better understanding of the outside world and instead of taking pleasure in fairy tales and day-dreaming they now are interested in concrete things. They are not interested in the abstract, but in adding to their stock of know-



ledge about the external world. Thus because of increased interest in the social and material environment the sex drive of young people in this stage is not strong and lies dormant.

### *The genital stage*

The period of latency is followed by the genital stage. With the onset of puberty young people's sex drive is revived and greatly strengthened, and they begin to take strong interest in their genitals. Usually they develop affection and attachment for members of their own sex. Masturbation is common in this period and homosexual tendency is common. One reason may be that boys and girls are not allowed by society to mix freely with each other, as there are social taboos and inhibitions. In adolescence there is plenty of sex jokes. Both boys and girls begin to take pride in themselves and satisfy their sexuality by loving themselves. Of course heterosexuality also emerges and the young person begins to dream of the kind of person he would like to have for his or her partner in life. In some cultures such thinking is encouraged so that young people are prepared for the later family life but in India where marriages are arranged they are not encouraged to think in that direction. There is great interest in personal appearance and both boys and girls are very particular about how they look and what clothes they wear. Their interest in the other sex sharpens and they are very self-conscious in the presence of members of the other sex.

### *Sexual abnormality*

The normal development of sex through the several stages has been briefly indicated above. Any departure from the normal is considered a perversion of sex. Sex is one of the most important biological functions and its expression and fulfilment in ways and channels other than the normal is considered with horror and is judged as depraved and sinful. Normal people do not realize the range, complexity and importance of sexual perversions and consider them with a good deal of abhorrence. It is because a frank and objective discussion till recently was considered indecent and undesirable. This prejudice applied even to medical men. All literature about sex, even the right and sane type, was taboo, and young

people were not given any knowledge or instruction about this most important biological function. It was Freud who laid bare the psychophysical processes underlying sexual behaviour and its abnormalities.

Sexual perversions stand for those types of behaviour in which release from sexual tension is obtained from practices and objects other than those of normal sexual person. These practices are associated with objects other than those with which sex behaviour is normally associated. They may involve contact of sex organs with other parts of the body like the mouth or the anus. Our conception of abnormal sexual behaviour, perversions or deviations depends also on our cultural standards. Kissing, polygamy, polyandry, prostitution and the like may be considered quite normal among certain people but may be condemned as deviations or perversions in another. Ignorance and hush-hush attitude toward sex is so widespread that our knowledge about sexual behaviour and its perversions is very scanty. Even within the same culture sex behaviour varies so widely from one class to another that it is difficult to say what constitutes abnormal sex behaviour. So a very general view is taken of sexual perversions that they are types of behaviour in which the individual knowingly seeks sex satisfaction and pleasure from objects other than those from which ordinarily normal people derive sex satisfaction.

Sex perversions are a long list :

1. Impotence and frigidity.
2. Satyriasis and nymphomania.
3. Incest.
4. Masturbation.
5. Homosexuality.
6. Podophilia.
7. Bestiality.
8. Exhibitionism.
9. Fetishism.
10. Necrophilia.
11. Sadism.
12. Masochism.



Some of them like masturbation are so common that it is not correct to describe them as perversions but they are included because society does not consider them normal. These deviations or perversions may be classified into three groups :

- (1) Those which are concerned with too intense or too weak a desire for sex gratification.
- (2) Those which involve normal biological behaviour but are not approved by society.
- (3) Those which are abnormal because their sex behaviour is directed toward an undesirable object.

We shall describe some of them briefly and others in detail according to their seriousness or their incidence in society.

### *Impotence and frigidity*

Impotence refers to the inability of the individual to obtain sex gratification. Unless it is due to physiological defect or impairment reasons for impotence are almost always psychological. No doubt worry, fatigue and various types of illness cause impotence but such effects are only temporary, and prolonged impotence before the age of 55 is rare. The important psychological factors contributing to impotence are fear, lack of emotional nearness to the sexual partner or homosexuality. In many young people excessive masturbation produces strong feelings of guilt and shyness. They not only feel inferior in the presence of members of the opposite sex but are afraid they would be inadequate in sex behaviour. Similarly, worry over business failures or over threats of social disgrace leading to violent emotional conflicts may cause temporary impotence. Or may be that sex desires are centred round members of the same sex resulting in a loss of feeling or even repulsion for members of one's own sex. Homosexual tendencies may cause impotence. Among men sex drive is connected with masculinity and strength and physically weak may develop strong feelings of inferiority, self-devaluation and impotence. They may be led to believe that they are not adequate, that something is wrong with them and that they cannot achieve marital happiness. Such people usually develop impotence.

Frigidity in the female is the counterpart of impotence in the male. But though impotence is not so common frigidity is very common. It is estimated that thirty per cent of the women are partially or completely frigid. If frigidity is not due to physiological defects the causes are essentially psychological, and relate to blocking of the sexual desire due to violent emotional conflicts. Some of the important causes of frigidity are undesirable early training, lack of emotional nearness of the marital partner, marriage to an unsuitable partner, fear of pregnancy or homosexual tendency. In many homes sex is described as lustful, bad and sinful and it has a serious reaction among girls who learn to shun it. A healthy, sane approach goes a long way to correct such attitudes and the resulting frigidity.

#### *Satyriasis and Nymphomania*

Satyriasis means excessive sexual activity on the part of the male and nymphomania means similarly excessive activity on the part of females. Their sex desires are intense and continuous, and all their behaviour is centred round sex. Their thinking, interests, jokes and general conversation are almost completely occupied with sexual themes. Such cases are almost always psychological and their abnormal sex interest may either be providing them with an escape from their problems, or a compensation for various frustrations or a means of impressing others with their strong masculinity or femininity. Such abnormal people frequently change their marriage partners and their domestic life is seldom happy. Often hostile desires against members of the opposite sex are present and the partner is very often rejected or punished after some time.

#### *Incest*

Incest refers to sexual relations between certain family members such as are not permitted by our cultural norms as for example between brothers and sisters or parents and sons and daughters. During adolescence young people often dream of sex relations with brothers or sisters, mother or fathers but in actual life such relations are not common. Among Hindus marriages between cousins are also prohibited, and in certain castes one may not marry in his own sub-caste. It is argued



that such prohibitions have a biological basis as they involve the danger of inbreeding such as the introduction of defects in the stock. On the other hand marrying outside the family and the sub-caste has definite advantages. It means associations with a larger group of people leading to economic and social advantages. Incest may lead to rivalries in the family. The very fact that it is revolting to the conscience of people of many cultures makes it very uncommon.

### *Masturbation*

It refers to the stimulation of one's own genital organs to obtain sexual pleasure. Though it is very strongly condemned it is a universal characteristic in infancy and puberty, and modern psychologists and medical men are not inclined to treat it as pathological. It is the most common outlet in pre-marital years and even among adults, and we may say that it is generally resorted to when opportunities for hetero-sexual relations are not available. That is why many progressive people eager to recognize the basic urgent needs of men and women are inclined to treat masturbation as normal. Many studies based on questionnaires reveal that about 90 per cent males and 80 per cent females remember masturbation experiences of younger days. Society strongly disapproves of it and it is likely that in many people the very memory of the experience may have been repressed. Psychiatrists and psychologists take a very sane view of the practice and insist that the feelings of fear and guilt associated with the practice should be removed in the interest of mental health. However, it involves a real danger in so far as if excessively indulged in it may impair health and interfere with the establishment of normal marriage relations. Or the fear or feelings of guilt associated with it may grow intense and lead to personality defects of serious nature.

Education both in the home and the school has taught us all that it is a sinful and wicked practice which will undermine our health, weaken our intelligence and eyes and lead to many kinds of mental and physical ailments and diseases. Religious and social reformers have built such a horrible attitude to it that there is a widespread impression at least among the young people that respectable people do not indulge in this

practice and, therefore, self-control is the highest virtue which young people must cultivate. The ideals of Brahmacharya are preached ad nauseam, and though they are commendable they indirectly help to build among young people very wrong attitudes to masturbation. Young people feel very guilty, promise that they will never do it again and it only adds to their tension and failure. Often they are led to believe that they have no strength of character, to fear that they are doing themselves the greatest harm and to develop feelings of guilt and inferiority. Then they may also be afraid that the consequences of their immoral behaviour may be found out by others. The fear of social disapproval and scorn makes matters worse for them, interferes with their healthy adjustment and creates problems of marital maladjustment.

Again there are certain conditions under which masturbation is very undesirable. It may be the result of the young person's loneliness, unhappiness and unwantedness and he may be trying to compensate through masturbation. Boys snubbed in the class, unable to afford luxuries which others have or coming from backward or poor homes feel frustrated, hostile and inadequate may be seeking compensation through masturbation.

Thus masturbation is not pathological as such but becomes so when it is closely associated with feelings of guilt, worry and self-devaluation.

### *Homosexuality*

It refers to sex and love relations between members of the same sex and is certainly the most frequent and from the point of view of psychiatry the most important of the perverse sexual relationships. It is found in all ages and in all cultures and affects many individuals who to all appearances are normal. Some of them are highly productive and intelligent. Society treats them with contempt and guards against them. Not only are they victims of personal conflicts but also of social conflicts. Homosexuality is almost as widespread among females as it is found among males though society takes less notice of this abnormality among females and even condones it when found.



Many states award very severe punishments to homosexuals when detected though in western countries a more lenient view is being taken of this abnormality, but modern abnormal psychology holds that this abnormality or deviation cannot be stopped or corrected by punishments, however severe. Society considers it a great crime and sin and people are not at all prepared to forgive or condone this perversion. Here is a conflict between laws and psychology.

We usually divide people into two sexes but homosexuality has upset this classification. Homosexuals are not stimulated by genitals of the opposite sex nor are they attracted by them. They are not interested in procreation. Freud stresses that but for this perversion such people are at a much higher stage of intellectual and moral development. Their claim is that they belong to a "third sex".

There is no doubt that homosexuals are grossly misunderstood and some people consider them to be a sort of social plague. Naturally it is difficult for such people to make adequate and satisfactory adjustments in work, marriage or social life. Many live in continual fear of being found out, of loss of employment and of social disgrace. Others have a strong sense of guilt and feel insecure and fearful. Some of them, however, boast as Freud has pointed out that they belong to a higher sex. Because many great men have been homosexuals these people claim that their perversion is a symptom of greatness.

Some scholars have conducted experiments with animals and birds by depriving the males the company of females for a prolonged period of time. They found that such male animals developed homosexuality and tried to have sexual relations and satisfaction from males. Later when they were restored to the company of females some of them avoided them and continued to enjoy the company of males. It is common that homosexual relations grow in social situations like schools, camps, prisons and the like because of the lack of opportunities for heterosexual relations.

Some attempts have been made to show that homosexuality is a hereditary defect but such attempts are deliberately made to establish that this perversion cannot be cured, it cannot be



changed or reduced and in any case the homosexual is not to be held responsible for it. But such an attitude does great injustice to homosexuals for some of them are eager to get rid of this perversion and can be cured by psychiatry. It is not the fault of heredity, it is neither a disease nor an inborn defect. It is simply a perversion of the sex drive. Homosexuals are anxious to win the sympathy of others by calling themselves unfortunate victims of heredity but the way they hanker after sex gratification and the amount of time and energy they spend on it show that they are escapists who want all the pleasures of sex without its responsibilities of procreation. If great men suffer from any disease like plague or flue it does not mean that these diseases are on that account desirable. Homosexuals are not normal and their social sense is not healthy.

Hirschfield regards them as belonging to the third sex, different from both men and women and traces homosexuality to certain influences on the fetus before birth. This is the orthodox view that homosexuality has a constitutional basis. It may be due to genetic inheritance or to physiological imbalance of the endocrine glands. Opposed to this is the psychological viewpoint in which emphasis is laid on the psychological factors and which is largely accepted by psychiatrists and psychologists. The constitutional view is based on evidence from histories of certain families in which this perversion is found in many generations and from investigations into glandular activity showing high percentage of feminine hormones in males and masculine hormones in females. But against this view it may be urged that many heterosexual people change over to homosexual and vice versa, and endocrine imbalance may often be found among people who are not at all homosexual. In fact some people claim that glandular imbalance may be the effect rather than the cause of sexual behaviour. It is true that many homosexuals use the constitutional argument to rationalize and condone their perversion.

Some of the important psychological factors leading to homosexuality are early homosexual experiences, bringing up a girl as a boy or a boy as a girl depending on the ardent wishes of the parents, close identification with the parent of the opposite



sex, unhappy social experiences with members of the opposite sex, frustration of prolonged nature with marriage relations and the like. Certain mental diseases like alcoholism, schizophrenia often predispose patients to homosexuality though no causal connection is known to exist between them.

The treatment of this perversion is rendered very difficult by deep-rooted prejudice in society that this perversion is a crime and the hatred and horror in which he is held. Nor are the homosexuals too eager to be cured. The few that are have been helped by psychiatry to change over to healthy marriage relations. The present mood of the society to track down such criminals and imprison them is hardly helpful to a constructive social campaign to reclaim them.

### *Pedophilia*

This refers to sex behaviour directed toward a child or an immature person. The incidence of this perversion is not large and both men and women have been found practising it. As some of them are quite normal, it seems to be a matter of faulty psychological development which somehow has interfered with the normal sex relations. Fear of rejection and humiliation by grown-ups may be another cause of pedophilia. Senile alcoholics may be found guilty of such a perversion. Society considers it a very serious offence and in most states it is punishable by long periods of imprisonment, and it seems just to do so as such perverts may cause not only physical injury but also very serious mental damage to young people.

### *Bestiality*

It refers to a perversion in which animals are used for sexual excitation and gratification. Large domestic animals like dogs, cats, calves and sheep have been so used. The lack of heterosexual opportunities in many secluded places is one of the main pre-disposing causes and often very affectionate bonds are established between the person and the pet animal. Another cause may be lack of adequacy or confidence in approaching members of the opposite sex. Some psychotic patients may also be found guilty of this offence.

*Exhibitionism*

This perversion refers to the excitation and gratification of sex urges by exposing genitals in public and semi-public places usually to members of the opposite sex. Sometimes this show is accompanied by all sorts of indecent gestures but more commonly it is only the exposure which is more important. This perversion is most common and in western countries it is most common in summer months. Young adult males are the main offenders. It is rare among women, and the police cases that are reported involve mostly men. May be that women cases are not reported. Pre-adolescent boys are usually guilty of it. Often the excitement and apprehension accompanying exposure makes the sex gratification more intense.

There are three factors which may be said to lead to such exhibitionism. In the first place the person's approach to sex is very immature marked by inadequacy and inferiority, shyness and over-attachment to mother. Secondly he may be suffering from castration complex and has a strong need to show that he is very masculine. Thirdly, the individual may have hostile attitudes toward members of the opposite sex and his exhibition may accord him an outlet for his hostility. In such cases he may knock down the victim after the show of genitals. Or it may be just lack of intelligence and feeble-minded people or alcoholics may be indulging in this perversion because they have no sense of its undesirability. Such cases should not be published and they can be treated by a psychiatrist without much difficulty.

*Necrophilia*

It refers to sexual excitation and gratification by sexual relations with a dead body. Although this perversion was known to the ancient people it is of very rare occurrence and is associated with severe types of mental disease.

*Sadism*

Sexual behaviour involves display of affection by kissing or fondling the sexual object but in sadism the individual is so perverted that he obtains sexual gratification by inflicting



pain on the object of his sexual gratification. The term is derived from the name of Marquis de Sade (1740-1814) who for sexual purposes inflicted such inhuman cruelty on his victim that he was considered insane and treated as such. Today the term is used in a general sense to include all types of cruelty involving infliction of pain to obtain sex gratification. Such cruelty may be physical as in biting, whipping, pinching or verbal as in throwing humiliating remarks at the sexual partner. Sadistic behaviour occurs on the part of males and may vary from mild biting and pinching to serious mutilation or even murder. In most cases such sadistic activities later lead to actual sexual relations but in some cases the sex gratification is obtained from the infliction of cruelty itself. Many sex murders show that the victim is not molested and the offender drew satisfaction from physical injury he inflicted on the victim. Let us consider some of the important factors involved in sadistic behaviour.

The most important factor is the general aggressive and hostile attitude toward others, and sexual sadism may be considered an expression of that general attitude. Human nature has destructive and hostile urges which to some extent give us a compensatory feeling of power, superiority and importance over others. Some people have feelings of revenge against the whole world because they were ill-treated by others in early life and they express their sadistic and revengeful hatred in many areas including that of sex.

Some people are brought up in extremely puritanical atmosphere and they consider all sex as sinful and degrading and as such they may derive satisfaction from inflicting injuries on members of the opposite sex. By such sadistic behaviour they express their contempt and their sadistic behaviour is a sort of punishment to the other person for engaging in sexual behaviour.

In the experience of some people sexual excitation is associated with the infliction of pain. In their young age they may have heard stories of assault on women by men or of cruelty to animals and such experiences may have roused sexual feelings unknowingly. It is only a case of strong, emotional situations being associated with sexual excitation, specially during the



period of adolescence. Usually young people grow out of them but in some such associations may become stable and permanent.

Sadistic behaviour may also grow out of the castration complex, that is, out of fear centering around injury or deprivation of the genitals as punishment for forbidden sexual desires. Sometimes the individual may be over-anxious to impress the member of the opposite sex that he does not lack masculine vigour or sexual potency and may inflict injuries to demonstrate that. Many sadists are under-sexed, timid and effeminate creatures and resort to sadistic activities to rouse themselves and their partners to more intense sexual activities.

Some scholars have tried to show sadism to be due to glandular imbalance, that is, defective secretion of the ductless glands of the body but such explanations do not go far and are not now accepted. Its origin must be sought in the early experience of the individual, that is, it must be tackled on a psychological level.

### *Masochism*

In masochism the individual obtains sexual excitation and gratification by inflicting pain on himself. Just as the term sadism has been used in a broad sense so the term masochism is being used in a wider sense to include bearing hardships and physical pain, flogging oneself to achieve religious expiation and purification, pleasure from self-denial. Here we shall confine ourselves to considering masochism as a form of sex perversion in which the individual enjoys physical pain being inflicted on him and this enjoyment involves sexual excitation and gratification.

Masochistic behaviour may vary from fantasies of ill-treatment to pain inflicting activities like cutting, pushing needles into one's body, spanking or abusing all of which are sexually stimulating. This type of behaviour is more common among women than men. It may be because in our culture women have to be more submissive than men in matters of sex and this submissiveness is related to pain and suffering. Four factors are said to work in masochistic behaviour. In the first place it may be claimed that masochistic behaviour is one example of the general masochistic



approach which the frustrations and defeats of life force upon us. We take the sting out of the reverses and misfortunes of life by plunging ourselves in misery and pain. Many religions like Christianity and Hinduism have sung the purifying virtues of pain and suffering as a means of achieving purification of the soul. Self-sacrifice is highly commended as one of the highest virtues in all faiths. When religious atmosphere is full of such thoughts people are most likely to develop attitudes of shame, guilt and degradation towards sex and the masochists have to pay the penalty for sexual pleasures. Only they pay the penalty before and not after the sexual activities. He may not like to suffer but such pain as he inflicts on himself makes sexual excitation and gratification easier. Secondly, as in sadism early experiences of the individual may be full of associations of sex with pain and he may have been reading stories and novels concerning masochistic behaviour or emotional situations in life may have been very violent and given him both pain and sexual excitement. Or his or her first sex experience may have been very painful. Many neglected children are severely punished and such punishment is the only attention and interest which their parents give them. Naturally they look upon punishment as a way of securing parental love and affection. Such people would like to be beaten or given pain by their marriage partner before they can have sexual gratification.

Thirdly, love expressions like being crushed in arms or smothered with kisses show that slight physical injuries may often increase sexual excitation and gratification. In women such emotional excitement as accompanies infliction of physical pain helps to increase sexual stimulation and satisfaction.

Fourthly, masochistic behaviour may be a reaction to sadistic activities. When sadism is repressed it finds outlet in masochism.

### *Treatment and Prevention of sexual perversions*

There are two aspects of sexual deviations and perversions, one to treat and cure the individual and the other to protect society from the harm such sexual deviants do. The latter is achieved in a general way by locking up the sexual pervert in a jail for

a long term, but it will be readily seen that this is not a very commendable way of treating him. It is only a way of getting rid of the problem and not of solving it. Ultimately any society will have to face the problem of treating and curing such people back to normal life and behaviour. It is obvious too that treatment will have to vary from one type of deviation to another and will also depend on the type of personality organization a particular individual has developed. The treatment of impotence in a normal individual will be different from that of a homosexual or a sadist. However, the broad general types of psychological treatment to be described hereinafter will apply. The individual will have to be helped to obtain a clear and deep insight into his problem, his emotions will have to be re-educated to express themselves in a healthy normal channel so that he learns to accept the normal outlets of sexual behaviour. Modern psychiatry has made considerable progress and the workers in the field are doing yeomen's service in reclaiming sexual offenders in all progressive countries. As a result of the spread of psychological knowledge society is also able to give more understanding and sympathy to sexual offenders.

It is often argued not without justification that with the spread of psychological knowledge a better understanding of abnormalities of sexual behaviour will prevail and will promote better understanding and appreciation of the difficulties of sex perverts, give these perverts insight into their abnormal behaviour, improve methods of upbringing in the family, make sex instruction more rational and fruitful and help to remove those psychological influences which induce sex abnormalities. Attempts are being made in progressive countries to set up hospitals for the treatment of sex disorders and with the reduction or decrease of social taboos about sex it should be possible to reduce the incidence of sexual deviations.

### QUESTIONS

1. Describe the main stages in the psychosexual development of the individual.
2. Describe the oedipus complex. What factors lead to its development?



3. What are the main abnormalities of sex behaviour? Give a brief account of each of them.
4. Discuss the factors working in masturbation and homosexuality. Are such factors constitutional or psychological?
5. Distinguish between sadism and masochism and explain the factors operating in these sex perversions.
6. Discuss in a general way the nature of sexual abnormalities. What in your view are the general causes of such abnormalities? How can they be best treated?



## CHAPTER 6

### Psychopathology of Everyday Life

In everyday life on different occasions we make such mistakes about which we are surprised and for which sometimes we feel sorry. When those mistakes are made we are not conscious of them but as soon as we have made them we begin to realize our mistakes. There are slips of the tongue and there are slips of pen. Addressing a very familiar person we may address him by a wrong name or we may not be able to recall his name just at the moment when we need it. Often we want to write one thing and write another or read something different from what is written. Similarly there are several bodily actions which are performed without knowing, as for example biting one's nails, picking one's nose, shrugging shoulders or sucking thumb among children. Few people do these things knowingly or willingly, there is an inner compulsion to do them. There is no doubt that such activities are found in many normal persons but Freud has called them abnormalities of daily life. They represent psychopathology of daily living. Many other scholars have tried to explain them by disturbances of the blood circulation, as due to inattention, chance or mental conflict but their explanations do not go far. People indulge in these activities even when they are free from these factors. Such actions are normal in the sense that they are found in otherwise normal persons, and they are not accompanied by any mental deviations. But they are abnormal in the sense that they cannot be explained by normal conscious behaviour and their source and origin has to be found in the unconscious. They are unconsciously motivated and they are determined by unconscious thoughts, wishes and desires. This has been revealed by psychoanalysis.

Let us discuss some of the important kinds of mistakes.

#### *Forgetting*

Although many factors work in forgetting, Freud is of the view that repression is the most important factor. It is very



powerful too. When we are unable to explain forgetting by any other cause we have to explain it by repression. Those thoughts and wishes which are painful and embarrassing, which humiliate us and injure our self-esteem we push them into the unconscious. Some painful and embarrassing memories cannot be forgotten even with our best effort ; it means that we do not have the capacity to repress them or some other thought or wish is being supported by this memory. When we are unable to recall the name of some very close friend, on psychoanalysis it is found that its reason was lying concealed in the unconscious. Often we excuse ourselves by saying that proper names are always difficult to remember. But Freud argues that there is always some reason for such forgetfulness. When some false name is substituted it is not mere chance that is working nor is memory functioning in a very arbitrary manner. The substitute name has some definite connection with the real forgotten name, and there is a motive in forgetting though it is unconscious. A person forgot the name of a town from where his friend brought some beautiful flower pots for him. He could not recall the name though he remembered perfectly well the name of the friend who brought the flower pots. On psychoanalysis it was revealed that the name of the town was associated with a river in which one of his dear relatives was drowned under tragic circumstances, the name was associated with very painful memories and these prevented the recall of the name of the town.

We often forget to pay bills or to post a letter. We often forget to pay debts. Such faults of memory occur in spite of our firm resolve to remember doing such acts. Just when the time for carrying out our resolve arrives we conveniently forget it. We may make up our mind to write a letter to a certain person but when we sit down it escapes our mind and we get busy with something else. If we do sit down to write it we may not complete it and if we complete it, it may remain lying on the table before it is posted or may be left unposted in some pocket. On some occasions we forget to write the address on such letters or to stamp them adequately. We are obviously not opposed to the writing or posting of such letters but repeated mistakes clearly show that in our behaviour there was a clear

tendency against them. When we forget the requests of some dear friend or the purchase of some articles specially advised by the wife it is indeed some repressed wish or desire that we are trying to gratify. May be that we do not recognize or accept the importance of such people or their requests or we overestimate our own importance to the neglect of others. Some repressed motive, desire or wish is the cause of such mistakes and it does not let the individual behave according to his conscious ideas and wishes.

Every beloved is a good psychologist and believes that her lover really does not wish to act according to her wishes and desires when he forgets to carry them out. That is why they do not bear any neglect on the part of their lovers.

Another example of such forgetting is the neglect of intentions and resolutions carefully formed. The individual has made up his mind to go to the market to make purchases for the family in the evening but his officer calls him and explains to him the urgency of some official work to be done. He himself is clear at the moment that the official work is much more important though he does not like that programme for the market should in any case be changed. Throughout the afternoon his mind was full of his resolutions both private and official. He did accept to do the official work without hesitation and he had no wish to ignore it but at the appropriate time he clean forgot to carry out the wishes of his superior. He had to bear a lot of rebuff and humiliation at his hands and he was full of genuine regret but psychoanalysis revealed that he really did not wish to carry out the officer's order and banished it into the unconscious, that is, repressed it.

One may forget the order of words and reproduce a poem by substituting a number of words in it. Such imperfect reproductions, with variations and gaps, are often put down to accident or faulty memory. Freud believes that they have a definite mechanism and are caused by repressed wishes and ideas. Brill reports of a brilliant young woman who in the course of a conversation recited :

In thy western house of gold  
Where thou livest in thy state,



Bards, that once sublimely told  
 Prosaic truths that came too late.

She hesitated many times during the recitation, being sure that there was something wrong with the last line. On looking up the book she found that not only the last line but even in other lines there were many other mistakes. The correct lines were :

In thy western halls of gold  
 When thou *sittest* in thy state  
 Bards, that *erst* sublimely told  
*Heroic deeds and songs of fate.*

Words in italics are those that were forgotten and replaced by others during the recitation.

The lady put it down to failure of memory but when asked on what occasion she memorized the lines she could not recall, said she was a teacher of elocution and had to memorize a good deal. It was suggested to her that when one is in love he or she is most likely to over-estimate the personality of one in love. "Was she in such a state for the lines do over-estimate personality of the lover?" She admitted she was and narrated how she fell in love with a young man she met in a theatrical performance. "He was training for a theatrical career and had all the desirable attributes for it. He was well-built, fascinating, impulsive, very clever and . . . very fickle-minded. She was warned against him but she paid no heed, attributing it all to the envy of her counsellors. Everything went well for a few months, when she received word that her Apollo, for whom she had memorized those lines, had eloped with and married a very wealthy young woman. A few years later she learned that he was living in a Western city, where he was taking care of his father-in-law's interests."

Brill continues : "The misquoted lines are now quite plain. The discussion about the over-estimation of personality among lovers unconsciously recalled to her a disagreeable experience, when she herself over-estimated the personality of the man she loved. She even thought he was a God, but he turned out to be worse than the average mortal. The episode could not come to the surface because it was determined by very disagreeable and

painful thoughts, but the unconscious variations in the poem plainly showed her mental state. The poetic expressions were not only changed to prosaic ones, but they clearly alluded to the whole episode".

Such forgotten or distorted material becomes connected through some associative road with an unconscious stream of thought which gives rise to the influence that comes to light as forgetting.

Freud refers to his own experience : "When I analyse those cases of name-forgetting occurring in myself, I find almost regularly that the name withheld shows some relation to a theme which concerns my own person, and is apt to provoke in me some strong and often painful emotions".<sup>1</sup>

Another example from the same source :

"A patient requested me to recommend to him a sanatorium in the Riviera. I knew of such a place very near Genoa, I also recalled the name of the German colleague who was in charge of the place, but the place itself I could not name, well as I believed I knew it. There was nothing left to do but ask the patient to wait, and to appeal quickly to the women of the family.

"Just what is the name of the place near Genoa where Dr. X has his small institution in which Mrs. So-and-So remained so long under treatment?"

"Of course, you would forget a name of that sort. The name is Nervi."

To be sure I have enough to do with nerves".<sup>2</sup>

### *Mistakes in speech or slips of tongue*

Slips of tongue are very common, we wish to say one thing and say quite another and sometimes it leads to very sorrowful results. Mayer and Meringer try to explain such mistakes of speech on the basis of similarities of phonetics but Freud does not accept their views. He is of the opinion that all such mistakes cannot be so explained. He attributes them to unconscious

<sup>1</sup> (Page 19, "Psychopathology of Everyday Life" by S. Freud, Collins).

<sup>2</sup> (Page 20, Ibid).



repressed wishes and desires. When a person says something different from what he intended to say he is certainly giving expression to his repressed unconscious wishes.

According to Freud speech blunders should be explained by the same mechanism which operates in the forgetting of names. When the word disturbances cannot be reduced to sound disturbances, as in the substitution and contamination of words the cause of the mistake in speech must be sought outside the words and their context and in physical influences. Meringer also admits this when certain words are substituted by others having the opposite meaning as for example what happened in the House of Deputies in Austria. The President was to declare the House "open" but instead he said : "Honoured Sirs, I announce the presence of so-and-so many gentlemen and, therefore, declare the session "closed." The general merriment first attracted his attention and he corrected the mistake. The probable explanation is that the President wished himself in a position to close the session, from which he had little good to expect, and the thought broke through at least partially resulting in the use of "closed" instead of "opened", that is, opposite of the statement intended. Freud says, "Numerous observations have taught me, however, that we frequently interchange contrasting words : they are already associated in our speech consciousness ; they lie very close together and are easily incorrectly invoked".<sup>1</sup> The mistake is an expression of the inner contradiction in the mind of the President, of the inhibited thought or wish. Freud gives a few interesting examples from his own experience which are repeated briefly :

(a) Seeing my daughter making an unpleasant face while biting into an apple I wished to quote the following couplet :

"The ape he is a funny sight,  
When in the apple he takes a bite".

But I began : The apel . . . " This seems to be a contamination of "ape" and "apple" or it may be conceived as an anticipation of the prepared "apple". The true state of affairs was, however, this : I began the quotation once before, and made no mistake the first time. I made the mistake only during the repetition which was necessary because my daughter, having been distracted

<sup>1</sup> (Page 40, Ibid.)

from another side, did not listen to me. This repetition with the added impatience to disburden myself of the sentence I must include in the motivation of the speech blunder."

(b) A woman, speaking about a game invented by her children and called by them "the man in the box" said "the manx in the boc". I could readily understand her mistake. It was while analysing her dream in which her husband is described as very generous in money matters—just the reverse of reality—that she made this speech blunder. The day before she had asked for a new set of furs, which her husband denied her, claiming that he could not afford to spend so much money. She upbraided him for his stinginess, "for putting away so much into the strong box" and mentioned a friend whose husband has not nearly his income, and yet has presented his wife with a mink coat for her birthday. The mistake is now comprehensible. The word *manx* (*manks*) now reduces itself to *minks* which she longs for and the box refers to her husband's stinginess."

(c) "Before calling on me a patient telephoned for an appointment and also wished to be informed about my consultation fee. He was told that the first consultation was ten dollars; after the examination was over he again asked what he was to pay, and added, "I don't like to owe money to any one especially to doctors. I prefer to pay right away". Instead of *pay* he said *play*. His last voluntary remarks and his mistake put me on my guard, but after a few more uncalled-for remarks he set me at ease by taking money from his pocket. He counted four paper dollars and was very chagrined and surprised that he had no more money with him, and promised to send me a cheque for the balance. I was sure that his mistake betrayed him, that he was only *playing* with me, but there was nothing to be done. At the end of a few weeks I sent him a bill for the balance and the letter was returned to me by the post office authorities marked "Not found".

(d) "I was to give a lecture to a woman. Her husband, upon whose request it was done, stood behind the door listening. At the end of my sermonizing, which had made a visible impression, I said, "Good-bye, Sir". To the experienced person I thus betrayed



the fact that the words were directed towards the husband ; that I had spoken to oblige him."

(e) Two young women stopped in front of a drug store, and one said to her companion, "If you wait a few *moments* I will soon be back", but she said *movements* instead. She was on her way to buy some castor oil for her child.

These instances have been cited from Freud's book to show that mistakes of speech are not due merely to similarity of sound but to other psychological factors which in the above cases are quite obvious.

### *Slips of pen*

Mistakes in writing occur when we write things other than what we intended. A person writes a letter to another and hopes he is "happy and dissatisfied" instead of writing "happy and satisfied" which he really meant to write. The reason for his mistake was that he in his unconscious wished him to be dissatisfied instead of satisfied. His friend got the job he himself had desired but failed to get, and that is why his unconscious desire found expression in his writing.

A young woman addressed a married woman friend as Miss instead of Mrs. On psychoanalysis it was found that the writer of the letter did not really wish to see her friend married because she herself was desirous of marrying the person who was married to her. She knew very well about her friend's marriage but her unconscious was not prepared to accept the fact. That is why she addressed her as Miss even though she knew her to be married. Such mistakes in writing express unconscious wishes and inner conflicts.

### *Misprints*

Mistakes in printing may be due to the faults of any of the people working in the press, the compositor, writer, proof-reader, editor or printer, and it is difficult to see them as mistakes of any one person, but nevertheless they do reveal unconscious urges of the person who makes them. Even the most well-managed newspapers are not free from topographical errors and the editors have often to apologize for them. They cause lot of

resentment, humiliation and disgrace, but sometimes they do give expression to repressed desires and thoughts and occasionally they are very amusing. A widely circulated weekly wrote, "Our readers will bear witness to the fact that we have always acted in a *selfish* manner for the good of the community." Obviously the word *unselfish* was meant but the real thoughts broke through the pathetic speech with elemental force.

Even the Bible has not escaped misprints and some of them have been of very serious nature. In 1631 edition the seventh commandment was printed to read, "Thou shall commit adultery" instead of "Thou shall not commit adultery" and the printer had to pay a fine of two thousand pounds for the omission. Authorities did not accept the plea that the mistake was accidental.

Such mistakes occur in typewriting also and the mechanism is the same.

An English newspaper reporting about the presence of a crown prince at some important function printed *clown prince*. When the mistake was noticed they expressed deep regret the following day and said that they did not mean *clown prince* but *crow prince*. Though they wanted to print crown prince their inner hatred and ill-will for the person made them commit the mistake again and again. How else can the repetition of mistakes be explained?

### *Mistakes of recognition*

Mistakes of recognition have been explained in a number of ways but Freud explains them on the basis of repression and conflict in the unconscious and regards them as a kind of abnormality. They are generally of two kinds. In one kind we mistake one thing for another. Often one is so full of ideas of another person that anybody resembling him is readily mistaken for him. Often children in the evening eagerly await the return home of their father and often look out in the direction in which he is expected. Many times they mistake another person resembling their father in some slight degree to be their father. Their over-eagerness is the cause of such faulty recognition. Often in a big crowd when we lose sight of a friend we wrongly address other persons by our friend's name. Old mothers eagerly awaiting



the arrival of their sons mistake every footstep to be that of their son.

In the second type of mistake of recognition the person is present but we fail to recognize or perceive him. The fact is that we do not recognize a person because we do not wish to recognize him. On the road we have very often to apologize to some people for not observing or recognizing them ; the plain fact sometimes is that we did not wish to recognize them. Our unconscious wishes are working and are responsible for such errors of recognition.

### *Mistakes of reading*

A woman who is very eager to get children always reads *storks* for *stocks*. Deep unconscious wishes burst into what we read and vitiate our reading. All of us have many experiences of misreading news in the daily papers and such mistakes are coloured by our own repressed wishes and desires. I told my wife that from next week our sugar ration was being reduced from 800 grams to 400 grams but when she read the paper she contradicted me saying that it would be 800 all right. When we both checked it we found that she had mistaken the Hindi four for the English eight. Poor dear, her anxiety to have more sugar could not help showing.

One of my students who had qualified that very year and was very eager to secure a job as lecturer in psychology brought me the daily paper that there was a job advertized and that I should write him a testimonial. On my asking him to show me the advertizement he scanned the Wanted Columns and could not find the needed advertizement. I took the paper from him and went through the columns myself and did not find such advertizement, but I hit upon one in which a lecturer for physiology was required and asked him if he had read that. He recognised the advertizement but was suprised to know his mistake.

### *Forgetting impressions*

This is a very common experience with a good many of us. We are sure that there is a watch repairer, a pen shop or a general store in a particular street but when we walk through that street we do not find any. We are surprised but are

not quite ready to accept that our impression was incorrect. One of my friends casually visiting us asked me, "Since when has your wife started wearing glasses?" I replied, "I do not quite know, but she has been using glasses for the last ten years or so".

"No, last time I met her about three weeks back she was not using glasses", he replied in surprise."

Later I came to know that he had been telling his own wife not to get glasses because my wife was not using any. His wrong impression was unconsciously motivated by his wish that his wife should not wear glasses irrespective of her need.

In social life a lot of misunderstanding is caused by wrong impressions formed about other people's attitudes and views.

A very important kind of such mistakes occurs when we mislay things. We are quite sure that we placed the keys on the table but they are not there. Somebody must have taken them and put them elsewhere. We search for them at all probable places where we feel we might have placed them but later when we find them we are convinced that we ourselves placed them where we have found them. It is a case of mistaken impression.

Brill relates an interesting case. "A man was urged by his wife to attend a social function in which he really took no interest. Yielding to his wife's entreaties, he began to take his dress suit from the trunk when he suddenly thought of shaving. After accomplishing this he returned to the trunk and found it locked. Despite a long, earnest search the key could not be found. A locksmith could not be found because it was a Sunday evening so that the couple had to send their regrets. On having the trunk opened the next morning the lost key was found within. The husband had absentmindedly dropped the key into the trunk and sprung the lock. He assured me that this was wholly unintentional and unconscious, but we know that he did not wish to go to this social affair. The mislaying of the key, therefore, lacked no motive".

Some of us are familiar with the mislaying of spectacles, and the joke is that we need another pair to search the pair mislaid. Often spectacles are found in places where they could not belong. Such mislaying cannot but be the acts of some unconscious intention.



*Forgetting of intentions*

No other phenomenon shows so well that the lack of attention is itself a symptom of inner conflict and repressed wishes as the forgetting of intentions. Freud defines intention as "an impulse for action which has already found approbation, but whose execution is postponed for a suitable occasion". But certain changes may come about between its formation and execution, it may be revised or some elements may be omitted. We often explain such changes as adjustments of motives but this is leaving them unexplained. Freud holds that such changes are due to certain interfering factors such as repressed wishes and unconscious urges. The army does not make any distinction between forgetting and intentional neglect and rightly so. The soldier dares forget nothing that military duty demands of him. If he forgets in spite of this, it must be due to the fact that the motives which urge the execution of action are opposed by contrary motives. He makes use of forgetting as an excuse.

In the morning the husband promises to buy certain household things on his way back home but he forgets. You promise a friend to do him a certain favour but at the right time you forget. How many of us do not fail to remember such things as condoling the death of a distant relative, sending a formal congratulatory telegram to a formal friend or relation? Freud speaks of inner opposition to conventional duty, for such people never forget when emotional pressure is great and their own feelings are concerned.

Brill cites an interesting example: "A patient found that she had suddenly become very negligent in her correspondence. She was naturally punctual and took pleasure in letter-writing, but for the last few weeks she simply could not bring herself to write a letter without exerting the greatest amount of effort. The explanation was quite simple. Some weeks before she had received an important letter calling for a categorical answer. She was undecided what to say, and, therefore, did not answer it at all. This indecision in the form of inhibition was unconsciously transferred to other letters and caused the inhibition against letter-writing in general."

Often we form false resolutions. At the time they are formed we were quite sincere about them but later we found



that they contradicted our previous resolutions or our more abiding interest and we had no hesitation in dropping them.

### *Mistakes of action*

Often the mistakes we make in action and behaviour are due to repressed desires and wishes. The action we wish to carry out in part or whole is done incorrectly or some other action is done in its place because it is consistent with repressed wishes. Freud holds that there is "some sense and purpose behind the slight functional disturbances of the daily life of some healthy people". Here are a few examples cited by Freud from his own experience :

(a) In former years when I made more calls at the homes of patients than I do now, it often happened, when I stood before a door where I should have knocked or rung the bell, that I would pull the key of my own house from my pocket only to replace it, quite abashed. When I investigated in what patient's home this occurred. I had to admit that the faulty action—taking out my key instead of ringing the bell—paying a certain tribute to the house where the error occurred. It was equivalent to the thought "Here I feel at home" as it happened only where I possessed the patient's regard. (Naturally I never rang my own bell.)

The faulty action was, therefore, a symbolic representation of a definite thought which was not accepted consciously as serious.

Breaking things, dropping crockery and using the wrong key to open a door are common errors of action but they are not as accidental as they are generally understood to be. They are really intentional if we take the unconscious factors into account.

(b) My inkstand is made of a flat piece of marble which is hollowed out for the reception of the glass inkwell; the inkwell has a marble cover with a knob of the same stone. A circle of bronze statuettes with small extra cotta figures is set behind the inkstand. I seated myself at the desk to write. I made a remarkably awkward outward movement with the hand holding pen-holder, and so swept the cover of the inkstand, which already lay on the desk, to the floor.



It is not difficult to find the explanation. Some hours before my sister had been in the room to look at some of my new acquisitions. She found them very pretty, and then remarked : "Now the desk really looks very well, only the inkstand does not match, you must get a prettier one." I accompanied my sister out and did not return for several hours. But then, as it seems, I performed the execution of the inkstand.

Did I perhaps conclude from my sister's words that she intended to present me with a prettier inkstand and did I shatter the unsightly old one in order to force her to carry out her signified intention? If that be so, then my swinging motion was only apparently awkward ; in reality it was most skilful and designed, as it understood how to avoid all the valuable objects located near it.

I actually believe that we must accept this explanation for a whole series of seemingly accidental awkward movements. It is true that on the surface these seem to show something violent and irregular, but on examination they seem to be dominated by some intention, and they accomplish their aim with certainty that cannot be generally credited to conscious arbitrary motions.

#### *Symptomatic and chance actions*

Chance actions differ from erroneously carried out actions in that they are carried out without any intention or pretext. They have no aim or purpose and are executed without any thought or wish, just by chance, just to keep hands busy or be doing something. Such information is often given to explain them and is readily accepted by those to whom it is given. They are insignificant and do not attract attention. Freud calls them "symptomatic" because he holds that they give expression to something which the actor does not suspect in them and which as a rule he has no intention of giving out to others. They thus play the part of symptoms.

Freud studied them in the course of his clinical practice and considers "symptomatic actions" a very suitable description of them. Anybody in the course of psychoanalytic treatment will come across a large number of them.

Some people pull their moustaches, take off their rings, button and unbutton their coat, or wash their hands in the air again and

again. To all appearances they are indulging in these activities only by the way just to keep themselves busy but psychoanalysts know that such acts are symbolic of deep inner conflicts and repressed wishes. Freud found in the course of psychoanalytic treatment that a woman in cutting her nails cut into the flesh of her finger on which she was wearing her wedding ring. It was revealed later that she was not very happy with her husband and the chance cut was symbolic of her inner unconscious conflict. Generally the person doing these chance acts knows nothing about them, he is even unaware of them and their effects on others. He does not know that others notice how he buttons and unbuttons his coat again and again or how he jingles coins in his pocket. Such acts are significant to the psychoanalyst. The interpretation of these trifling chance actions, as well as the proof of their interpretation, can be demonstrated with certainty every time from the surrounding circumstances during the treatment and from the ideas that come to surface when these chance actions are analysed.

To the psychotherapist these symbolic actions are of great value for they reveal a great deal about the inner troubles of the individual and they are found in abundance in a healthy as well as a nervous person. Here is an example from Freud.

"During a summer tour it happened that I had to wait several days at a certain place for the arrival of my travelling companions. In the meantime I made the acquaintance of a young man, who also seemed lonely and was quite willing to join me. As we lived at the same hotel it was quite natural that we should take all our meals and our walks together.

On the afternoon of the third day he suddenly informed me that he expected his wife to arrive by that evening's express train. My psychological interest was now aroused, as it had already struck me that morning that my companion rejected my proposal to make a long excursion, and in our short walk he objected to a certain path as too steep and dangerous. During our afternoon walk he suddenly thought that I must be hungry and insisted that I should not delay my evening meal on his account, that he would not sup before his wife arrived. I understood the hint and seated myself at the table while he went to the station.



The next morning we met in the foyer of the hotel. He presented me to his wife, and added, "of course, you will breakfast with us." I had to attend first to a small matter in the next street, but assured him that I would return shortly. Later as I entered the breakfast room, I noticed that the couple were at a small table near the window, both seated on the same side of it. On the opposite side there was only one chair, which was covered, however, with a man's large and heavy coat. I understood well the meaning of this unintentional, none the less expressive, disposition of the coat. It meant this: "There is no room for you here, you are superfluous now".

The man did not notice that I remained standing before the table, being unable to take the seat, but his wife noticed it and quickly nudged her husband and whispered: "Why, you have covered the gentleman's place with your coat."

#### *Critical Comments.*

Freud has given a number of examples of daily deviations in which more than one factor operates and the list of daily abnormalities described above indicates the various ways in which repressed unconscious wishes which we do not acknowledge influence our mistakes, chance errors or acts, misplacing of objects and the like. Freud is quite clear that these are the result of unconscious motivations. But other scholars do not fully agree with his conclusions. Their main criticism is that Freud's explanations are subjective and do not have any scientific value. But this criticism is not fair considering that later investigations by dream-analysis, free association and the like support them and demonstrate their validity beyond doubt.

In the beginning what behaviour appeared to us as improper, doubtful, meaningless or aimless turns out to be consistent with hidden urges, clear and meaningful. Freud has demonstrated fully the truth and validity of his explanations by examples from all areas of life and work. When a husband forgets to buy things his wife had requested him to buy the wife's anger is very proper and justified for hidden urges and wishes of the husband have worked against her. She rightly thinks that her husband did not really wish to make those purchases. When a soldier disobeys or fails to carry out orders pleading that he

forgot about them his officers are right in not accepting his plea. In both cases forgetfulness is due to negligence though the individual is not fully aware of it. Also most of our actions which are commonly believed to be accidental, casual or due to chance are very meaningful for they are motivated and throw a great deal of light on the inner working of the mind of the person concerned. According to Freud no behaviour is meaningless or purposeless. Even the most trivial acts are motivated albeit unconsciously. That Freud's explanations of the psychopathology of daily life have helped us to acquire a better understanding of human behaviour and its springs cannot be denied. Our errors, mistakes and deviations are now much more intelligible and many people as a result of the study of abnormal psychology have begun to analyse their behaviour and understand their apparently meaningless acts and errors. Habits of self-analysis will certainly contribute to better understanding and control of behaviour and help to avoid abnormalities.

### QUESTIONS

1. What do you understand by "Psychopathology of daily life? Describe some of its forms giving examples from your own life and experience.
2. Why do we forget? Give some of the common and important reasons with examples. Can forgetting be accepted as a reasonable excuse for not doing anything?
3. Have you ever misquoted lines of poetry? Give examples and try to explain such errors.
4. Give some examples of slips of pen and tongue and explain how they occurred.
5. Give some examples from your own experience of having misplaced things and try to explain them.
6. Give examples of mistakes of recognition and printing.
7. What are the mistakes of action and chance actions? Explain them with examples.
8. Discuss critically Freud's attempt to explain the psychopathology of daily life. Do you agree with him fully? If not, why?



## The general nature of psychoneuroses

### *What is psychoneurosis?*

Psychoneuroses are also known as neuroses. They are milder forms of mental ailments which give lot of trouble to the individual and make life very difficult for him, though he is still able to carry on his daily activities in a fairly normal way. A person suffering from neurosis or a neurotic does not suffer from delusions or hallucinations nor does he behave in a violent manner toward himself or toward society. Only he is unhappy, anxious, inefficient and ineffective. He does not need any regular treatment in a hospital but he is badly in need of help from a psychiatrist. Because of conscious or unconscious conflicts he is prevented from making the best constructive use of his abilities and talents and from developing happy and harmonious social relationships. Generally psychoneuroses are brought about by severe emotional strain, conflicts and frustrations, and they can be most effectively treated by psychological techniques. They are not caused by physical disorders and the ordinary medical treatment has no effect on them. A neurotic is a source of serious disturbance to his friends and companions and his symptoms are such that he does not need any serious hospitalization nor need he be separated from his family or friends. Most of the neurotics live at home with their family and carry on their normal duties and work and fulfil their professional and social obligations.

### *Symptoms of psychoneurotics*

Let us study some of the common symptoms of psychoneuroses. In the first place the patients suffer from *anxiety and fearfulness*. They are afraid of meeting people in social or business situations, and generally keep away from them. They have a timid approach to life and are always fearing some disaster or catastrophe to happen to them or they may be fearing some disease to be falling to their lot. It means that they cannot enter into competition

with others nor take a vigorous share in the life of the community. It would mean that they have feelings of inferiority and since life and work involve coming to the fore and making up one's mind such people are irresolute and indecisive. If they ever take a decisive step they have misgivings and are assailed by doubts, regrets and worry.

Secondly, he is *over-sensitive* and has extreme and intensive reactions to both painful and pleasurable aspects of experience. Minor set-backs upset him as minor successes elate him. He avoids situations in which he may have to compete with others for any slight reverse is sure to add to his insecurity, inferiority and fearfulness. He is too easily pleased by flattery as he is too readily upset by criticism. Neurotics are highly sensitive, touch-me-nots. They are very irritable and morbid.

Thirdly, they *lack maturity* and independence. They are not self-reliant and wish to have other people's support, sympathy and help. Whenever they enter into a new venture they would like some friends and relations to join, accompany or participate with them. Or they may rush to the other extreme and disdain other people's help and support just to show off their independence. Some of them believe that marriage will solve all their problems and they seek self-assurance and security from their partner. Often they are disillusioned after the marriage. They are prone to build high hopes and ambitions and these are later belied to their great disappointment.

Fourthly, a neurotic is very strongly *self-centred and self-conscious*. All his thoughts, feelings and actions, all his hopes and enthusiasms, his fears and anxieties are about himself. He is very much concerned about his status, importance and prestige. He is very sensitive about other people's attitude toward him and about his own attitude toward others. He is ill at ease when he has to mix with his superiors or to participate in social functions. He is constantly comparing himself with others, how he stands in relation to them in status, ability or power. Such comparisons always give him feelings of inferiority and lead to self-devaluation.

Fifthly, a neurotic is always complaining of a number of



*physical ailments* like tiredness, indigestion, headaches and sleeplessness. As has already been pointed out causes of such complaints are psychological and they cannot be treated medically. They are called *somatic* troubles on that account. In psychoneuroses motor and sensory functions are disturbed, voluntary control over them may be lost, the patient may suffer from shortness of breath, tension, palpitation or stomach troubles. His heart, stomach and temperature may be irregular and upset, and he may feel aches and pains all over his body or in some of the limbs.

Lastly he may be very much *dissatisfied* and *unhappy*. This, of course, is quite obvious and follows from his anxiety, worry, tension, somatic troubles. His approach to life and its problems and tasks is pessimistic. He seldom feels self-assured, respected, adequate or esteemed and, therefore, his general outlook is downish and depressing.

Not all the symptoms described above are present in any one individual at the same time, and their intensity also varies from person to person. Most of us are bound to be unhappy and anxious in the face of difficulties and strains, but a good many are able to recover their balance and peace of mind after putting up a hard struggle. The neurotic employs these symptoms permanently while a normal person may use them only for the time being when facing stress situations.

### *Incidence*

Psychoneurotic symptoms are fairly widespread in varying degrees. No records are available in India and no studies have been made of the incidence of psychoneuroses in this country. We have to depend on figures quoted from the United States. Page thinks that at any given time 5 to 10 per cent of the population give evidence of neuroses and their symptoms and in moments of strain and crisis some 20 per cent people may show psychoneurotic reactions. In some industries some 60 per cent of the time lost through sickness is due to neurotic illness of some kind. Medical opinion in the United States places 30 to 50 per cent people seeking medical assistance in the class of neurotic patients who do not suffer from any physical



ailment and whose trouble is entirely psychological. They do not need any medicine and yet seek it, and they can be treated only psychologically.

### *Classification of psychoneuroses*

It is not possible to classify psychoneuroses on any definite basis except that of clear symptoms but the difficulty is that very well-defined symptoms of many groups are often observed in many patients. Any attempt to place any patient in a particular category of trouble is bound to be difficult and unsuccessful. Let us, therefore, follow the traditional approach and deal with the four types of psychoneuroses which are generally recognized. They are *neurasthenia*, *hysteria*, *anxiety state* and *psychasthenia*. We will describe them here very briefly and take up their detailed treatment later.

*Neurasthenia* is marked by a feeling of fatigue or exhaustion. It means loss of energy, nervous exhaustion. Patients suffering from this psychoneurosis complain that they lack power and energy, are unable to concentrate, suffer from chronic fatigue both mental and physical, they have muscular pains and aches, their gastrointestinal system is disturbed, they are irritable and cannot take initiative in doing new things.

Closely related to this disorder is *hypochondria*. The patient believes that he is suffering from numerous diseases, he is morbidly anxious about his health and in his imagination he sees himself suffering from numerous troubles. Therefore, he pays considerable attention to the several functions of his mind and body and is always analysing and describing them to others. He is intensely interested in medicines of all kinds and is very eager to consult doctors. Symptoms of hypochondria are generally present in most patients of neurasthenia.

*Hysteria* is marked by loss of function. Typical symptoms of hysteria are paralysis of limbs, blindness, deafness, loss of memory and insensitivity of the skin. These symptoms are not the result of physiological causes but have psychological origin.

*Anxiety states* are marked by intense emotional reactions. The patient is generally agitated and tense, feels insecure and



restless ; he is generally afraid that something dreadful is going to happen to him, he may tremble, feel dizzy ; and there may be loss of sleep, disturbed digestion, palpitation and excessive sweating.

*Psychasthenia* includes 'obsessive-compulsive reactions and phobias, but since the two types have symptoms of independent origin the term is being more and more rarely used and the two types of psychoneuroses are being treated separately. Obsessive-compulsive reactions involve irresistible and persistent urges to do, say or think about certain things such as counting steps or poles on the road, repeat words, touch objects or do things again and again. Phobias are abnormal fears of intense kind. Normal fears arise in dangerous situations or in the face of dangerous objects but phobias are irrational and groundless and arise in situations in which normal people do not feel any fear. Some are afraid of water, others of high places or dark rooms ; some fear lonely places others are in a panic when they are in a crowd. Some people have an exaggerated dread of germs and dogs.

Some kinds of psychoneuroses arise in certain situations and are given descriptive names related to those situations. Army personnel at the front and in combat situations develop what is called *war neurosis*. People involved in some accident and sustaining injuries in the head may develop what is called *traumatic neurosis*. Psychoneuroses are also peculiar to one's occupation and the individual loses the skill necessary in that occupation. Some writers develop writer's cramp and their right hand refuses to write or the telephone operators lose voice and are unable to speak. In a sense it may be claimed that in such situations, psychoneuroses are not different from ordinary types of neuroses inasmuch as their symptoms are the same except that they are coloured by situations in which they occur. It may be that the psychoneurotic symptoms were already present in a latent form and wars, occupations or head injuries precipitate them. But even then they have to be treated in detail because in the absence of such situational factors they might not at all have been revealed or expressed.

*Causes and origins of psychoneuroses*

Causes and origins of psychoneuroses have been described to be entirely psychological but it is not possible to separate mind from body and the close relation between the two implies that physical factors are sure to affect the development of psychoneuroses. It is true that they are psychological disorders and cannot be traced to any physical trouble or ailment but since physical factors may add to or subtract from our mental resources they may to that extent help or hinder neurotic symptoms. But even then such instances are rare and the physical health of neurotics is as good as that of normal individuals. However many neurotic individuals genuinely believe that their run-down condition is due to over-work, physical exhaustion or weakened digestion, but often these physical symptoms are themselves the result of psychological causes. For example it is only an individual very much harassed by conflicts and worries who indulges in over-work, tires himself to exhaustion and thus allows his digestive system to fail. These physical factors are themselves symptoms of some underlying psychological trouble which may involve loss of sleep, power to concentrate, appetite and general health.

Case histories of numerous psychoneurotics reveal that the appearance of psychoneurotic symptoms is generally preceded by violent emotional conflict or distressing emotional experiences, financial loss in business, disappointment in love, domestic quarrel or violent discord with friends and neighbours, some tragedy in the family, death of a dear one, some frightening accident or failure to adjust to the requirements of one's occupation. Such experiences cause great disturbance in mind and because they precede the appearance of psychoneurotic symptoms, one is tempted to believe that they are the cause of such symptoms. This however is not true, because almost everyone is subject to such experiences but certainly everybody does not become a psychoneurotic. Everybody meets with obstacles and reverses in life, disappointments and tragedies, set-backs and shocks, strains and stresses, trials and tribulations. They do not occur with greater frequency in the lives of psychoneurotics. Normal people accept such experiences as a part of the game



of living and those who are potential neurotics succumb to them and are unable to meet their challenge. It would mean that such experiences are predisposing causes of psychoneuroses but those who suffer from them have already the germs of emotional instability. Their tendencies to psychoneurosis already exist and all that these experiences do is to strengthen and develop them.

This means that there is something in the very constitution of individuals which inclines them to psychoneurosis. Heredity and environmental influences determine the growth and development of tendencies to psychoneuroses. If environmental influences are favourable the individual may be able to get over such tendencies or at least be able to hold them in check for some time but if they are unfavourable such tendencies may grow and psychoneurotic symptoms may appear under the stress of difficult events in the life of any individual. It is very difficult to separate the influences of heredity and environment since members of a family share the same environment and what is ascribed to heredity may be due to similarity of environment.

Some authors are inclined to draw a distinction between heredity and constitution, while others use them as synonymous. No doubt the most important determining influences in constitutional tendencies are hereditary factors, but constitutional factors are those which have a long-range influence on the bodily and psychological reaction tendencies of the organism. Influences during natal period, birth injury, iodine deficiency and the like may prevent normal development. These are constitutional factors though they are often confused with heredity.

Equally important is unfavourable early training and environment. If early life in the home and the school is full of all sorts of tensions, annoyances, fears and anxieties children are likely to develop instability of mind and become hypersensitive. Disturbing experiences provoke all sorts of maladjustments and pave the way for psychoneurotic symptoms. If the mother is over-affectionate or over-strict, if she rejects the child, if her attachment to the child is abnormal, if there is frequent discord between parents, if the home is broken for various personal reasons, if there is acute rivalry among children of the family, if parents or elder brothers or sisters are over-



bearing and domineering, children are sure to develop neurotic symptoms in later life. It must be said to the credit of the psychoanalysts that they have stressed the importance of early childhood experiences as determining the pattern of adult personality in a manner and degree to which it was never stressed before. Only mentally healthy children can produce mentally healthy adults, and if well-balanced personality is to be developed children should not be exposed to unhealthy influences. At least for the sake of children parents should put on decent normal behaviour and avoid making a display of temper and behaviour which may distort children's outlook on life.

Some psychologists like Prince have emphasized the role of *conditioning or association* in causing neurotic symptoms. Our feelings and emotions when experienced under stress conditions as an accident or a tragedy get so associated with chance factors and things that later they are aroused by them instead of the usual factors and things. A person who suffered from nausea, dizziness and headache following a railway accident may experience the same symptoms when he later rides a train. A child is frightened by a loud noise, but when it is made in the presence of a cat or a dog fear gets conditioned to that animal, and later he feels fear whenever he faces a dog or a cat. As we shall see later this concept of conditioning is very helpful in explaining and understanding some of the absurd fears which people develop. As Page points out conditioning can explain psychoneurotic symptoms but cannot give us any clue to the understanding of the causes of psychoneuroses. Hollingworth thinks that psychoneurosis is due to "unserviceable habit adjustments" and to be neurotic is to be always forming such habits through association and conditioning.

#### *Characteristics of patients of psychoneuroses*

Nearly 60 per cent of people suffering from psychoneuroses, as observed in various hospitals and sanatoria in the United States, are women. Page thinks that excess of women over men is due to the fact that about 75 per cent of hysteria patients are women. In other types of psychoneuroses the number of women and men sufferers is the same.



People of all ages from childhood to old age suffer from psychoneuroses but the highest frequency is to be found from the early twenties to late fifties. The average age of patients is about forty. Perhaps this is the age when a person is called upon to face trials and tribulations most. But in many individuals the symptoms are appearing and disappearing with the onset of strain and stress in daily life.

In intelligence psychoneurotics compare very favourably with the rest of the population. Most patients possess average intelligence but neuroses are more prevalent among bright than dull people. Patients of hysteria are on an average less intelligent than those suffering from other types of neuroses.

Social and economic status of patients has also been studied. It has been revealed that among people of wealth and better education hysteria claims only 15 per cent while anxiety state claims as many as 40 per cent. This finding is further strengthened by figures obtained from the army personnel. Lower ranks suffer more from hysteria and higher ranks mostly from anxiety state.

Psychoneurotic patients also reveal several characteristic personality traits. They are generally unhappy, dissatisfied, lacking in self-confidence. Feelings of inferiority and inadequacy prevent them from going all out for competitive outdoor activities, taking quick decisions and following them up with action. They are less effective and efficient persons. They are sensitive, inclined to blame others, emotionally raw, unstable and immature. They are not inclined to participate in any social service work but they are very particular about what others think about them. As they have feelings of guilt and insecurity they cannot enjoy life and are not good mixers.

### *Nervousness and neurosis*

Too many people use these two terms interchangeably but this is not correct. In the first place nervousness means a large variety of reactions and secondly a small proportion of nervous people are really neurotic. The term nervous is applied usually to people who are restless, easily upset and unable to concentrate attention. They may bite their nails, play with their handkerchief

or buttons or mop their forehead. These meaningless acts help them to get over their tension and offer release for their pent-up activity.

The common term nervous-breakdown is loosely used to denote psychoneuroses, psychoses, mental derangement, mental impairment or physical exhaustion and should not be used in any scientific discussion of behaviour.

### *Leading traits of neurotic persons*

All of us have from time to time given evidence of symptoms of neuroses indicated above, that is, we are unable to concentrate, worry a good deal and the like, but we become abnormal only when these symptoms become excessive and habitual. We shall now describe other traits of persons who are neurotically maladjusted, traits that may not occur in all cases, but which are so frequent that they are conspicuous symptoms, and frequent causes also, of maladjustments.

Psychoneurotics worry a lot and this worrying habit is characteristic of serious neurotic conditions. Often it aggravates such conditions. Neurotics worry over many things and over many problems, but these things and problems are seldom the object of their worry. In fact worry is a means of avoiding serious problems and attending to minor things. Financial and family difficulties may cause worry but the patient makes no attempt to solve them, nor does he make any effort to stop worrying.

Neurotics are generally given to *introspection* or *self-examination*. It appears even in milder maladjustments and contributes to their development into more serious forms. They may be constantly judging what progress they have made and may not have very clear motives. Excessive self-examination is often the result of worry and worrying too much leads to worrying about oneself and introspection. Self-examination makes an individual ask: How do I feel? What sort of person am I? What do other people think about me? What sort of treatment do I get from others? He becomes so self-centred that he measures his environment and other people in terms of his own feelings and interests.

Too much worry and introspection make the patient think only of his *happiness* and *unhappiness*. Neurotics often complain that they are very unhappy and pursue happiness as an objective.



But happiness is a worthy object only if it includes happiness of others as well. Like other ideals happiness is best achieved if it is ignored most of the time. If one is most of the time over-concerned with happiness he is most likely to miss it. Too much pre-occupation with one's happiness is sure to make him unhappy and is a trait of neurosis, and may help to make it worse.

*The consciousness of a neurotic is inverted.* A normal person is busy seeking goals with reference to his world and gives little attention to his feelings and bodily processes. He may attend to them when he is ill or has an organic trouble. But a neurotic attends to them as his main concern and ignores the real outer world. In the world of events and things it does not matter how a particular individual feels or thinks; his feelings and bodily processes like pains and aches are important when they are so acute as to interfere with his life and work and then they must be treated by a doctor.

*Egoism* of the extreme kind is peculiar to a neurotic and spoils his social relations. He may try to monopolize the conversation and remain in the limelight, he may try to dominate and indulge in excessive self-assertion, and he thus incurs the displeasure of others. Or he may withdraw himself from social life and become a recluse avoiding the company of others. His selfishness leads to disapproval of others. In either case he becomes a very unpleasant person. Withdrawal from social contacts and experiences is not only a symptom of neurosis but also the aggravating cause of it.

Almost every neurotic indulges in *self-pity*. He is always pitying himself. He believes that he is a victim of misfortunes and calamities over which he has no control and for which he is not responsible. This self-pity together with worry and self-examination makes him ascribe his misfortunes to others and fills him with resentment for them. He is always complaining that the world has no sympathy or humanity, and he expects other people to treat him with consideration while he himself does not show any for them.

Neurotics are highly *suggestible* and *obstinate*. In a way all people are suggestible and obstinate at times and in a

neurotic these traits are found in excess and in an exaggerated form. A person is said to be suggestible when he readily and easily, without critical analysis, accepts ideas or opinions from others, and we all accept ideas and opinions from others, but a neurotic does so much oftener, and once he has accepted an opinion he clings to it with obstinacy and steadfastness.

### *Significance of neurotic symptoms*

Common people do not take a neurotic seriously and when he complains of tiredness, headache or paralysis of any limb they make fun of him and accuse him of pretending or imagining things. The trouble is that his troubles are psychological, no bodily things. The trouble is that his troubles are psychological, no bodily cause can be assigned to them and people usually believe that psychological troubles are of our own making and that we can shake them off by an effort of will. This is not so. Psycho-neurotic symptoms are very real, when a person says he is tired he is not merely imagining things, he is really tired and the hysteria patient is paralysed. A person who gets nervous and excited while about to make a speech before an audience becomes tongue-tied, perspires and trembles is not faking or imagining, his psychological condition of the moment has produced these physical symptoms, and they disappear when he sits down and has no longer to face any audience. In fact such bodily reactions though very embarrassing save the speaker from making any speech. An old person complains of bodily pains and aches, he does not imagine them nor does he enjoy them, but they provide him with a convenient escape from some intolerable family situation or financial crisis. Illness releases him from responsibilities and he receives special attention. Similarly counting steps or poles may be very annoying but it helps him to avoid something disagreeable. But such a neurotic does not consciously plan to escape through such symptoms, he is not a malingerer. He is not trying to deceive others, he is only trying to persuade himself that he is very ill. He is not fully aware of the meaning and purpose of his symptoms or of the conflict which compels him to resort to such adjustments. Such symptoms are attempts at adjustment to a difficult situation and this adjustment takes place at the unconscious level.



*Psychoneuroses and psychoses*

A comparison between neuroses and psychoses will not only bring out differences between the two but also help to make our knowledge and understanding of each type of disorder clear and definite. Psychoses are far more serious disorders than psychoneuroses but this does not mean the latter lead to the former. According to Page only 5 to 7 per cent of psychoneuroses develop psychoses, and even of this number it is likely that they were psychotic to begin with but their symptoms showed themselves later. Only 5 to 10 per cent of the general population give evidence of psychotic symptoms. Detailed studies made in America show that only 5 per cent parents of psychoneurotic patients show psychotic symptoms. Let us study some of the differences between psychoneuroses and psychoses.

In psychoneuroses psychogenic factors, that is, factors of psychological origin, are of considerable importance, heredity too is important, but chemical and neurophysical factors are of no significance. On the other hand in psychoses hereditary, neurophysical and toxic factors are the determining agents and factors of psychological origin are insignificant. Poison whether inherited or acquired along with biological inheritance is the main cause of psychotic conditions, but neuroses are caused by psychological factors like conflicts, tensions, emotional disturbances, shocks and the like.

It is in general behaviour that the difference between the two stands out most significantly. A psychoneurotic does not differ much from a normal person. He is responsible for his actions, self-supporting, actively participating in the life of the community, his movements, speech and thinking are coherent and logical. He is fairly conscious of his condition and takes due notice of changes in his environment, and he makes effective adjustments to changes in the physical and social environment. But the psychotic is far different from the normal, his actions, speech and thinking are incoherent, bizarre and irrational ; he suffers from hallucinations and delusions, he is mentally confused and his emotional responses have no relation to the social environment in which he is placed at any moment. A psychoneurotic never loses touch with reality and the social situations while a psychotic is utterly

devoid of any social habits ; the behaviour of the former fully accords with the accepted standards of social groups but that of the latter does not take any notice of what is happening around him. Thus the two differ very vitally in personality disturbance and social functioning.

A psychoneurotic is capable of managing his own affairs, he does earn his living and supports himself and his family, and except for slight inconvenience to his relatives and friends he is seldom dangerous to others, and rarely suicidal, but a psychotic on the other hand, is incapable of looking after himself, cannot manage his affairs, is dangerous to people around him and may commit suicide if not carefully looked after. That is why he is often treated in special hospitals. A psychoneurotic maintains his identity and his personality differs little from his normal self. But a psychotic's personality undergoes a radical change, he acts and looks a different person altogether.

A neurotic often has a fair insight into the nature of his trouble and behaviour but a psychotic has no understanding of his trouble or behaviour. A psychoneurotic does understand that worry is doing him harm but a psychotic who claims that he is Nehru is not concerned if you try to prove to him that he is wrong. In psychoses there is a break with reality and the patient may not only injure himself but also his fellow-beings. That is why his removal to special institutions is necessary consistent with the welfare and best interests of others. Patients usually require medical treatment besides psychotherapy, they may have to be given electric shocks. But patients of psychoneuroses do not need any hospital treatment, their symptoms are transitory and they are usually curable. There is no danger and the mortality rate is normal. In the treatment of psychoses the outlook is seldom hopeful, in most cases the patients gradually worsen and the death rate is high.

To sum up : Each has its special symptoms, more or less peculiar to it. For example, attacks of anxiety and obsessional thoughts are neurotic symptoms. Delusions that others are persecuting the patient and severe hallucinations are psychotic symptoms. Generally the psychotic disorders are much more incapacitating and continuous than the neurotic ones. Contact with,



and appreciation of, reality is much more disturbed in psychoses than in neuroses. And the neurotic patients can be influenced much more easily than the psychotic patients.

This is a general distinction but it will get more defined when we study neuroses and psychoses, at least of the functional type, in greater detail.

### *Theories of psychoneuroses*

Pierre Janet, a French psychiatrist did pioneer work in the field of psychoneuroses. He was the first to classify and interpret neuroses. He found that hypnotized hysterical patients can recall events unremembered in the normal state. A forgotten emotional shock, for instance, would be revealed and thus give a clue to the causes of neurosis. By suggesting during the trance that the upsetting event was past and gone, Janet was able to make many symptoms disappear. He developed a theory that hysteria is a "dissociation" of personality, that it is an imperfect integration of personality. Normal personalities are well integrated. Hysterical personalities are split and subject to internal division.

From this investigation he concluded that neuroses are due to psychological tension, nervous exhaustion and mental dissociation. He believed that a certain degree of mental tension is necessary for integration of mental phenomena but when this mental energy is lowered integration and synthesis of personality is destroyed and the appearance of symptoms which are of a lower type of behaviour is made easy. Thus physical disease, excessive fatigue which lowers the level of mental energy and emotional shocks pave the way for neurotic symptoms.

Janet put forward only two types of psychoneuroses, hysteria and psychasthenia. When the lowering of nervous energy is localized and only specific functions are affected there is hysteria. In hysteria certain functions and ideas are lost. The weak mind in a way gives them up. All symptoms not included under hysteria are grouped under psychasthenia. This with him was a general heading for phobias, compulsions and obsessions, even for such reactions as are found in neurasthenia and anxiety states.

Neuroses, Janet believed, arise from constitutional weakness and lack of energy, possibly with a hereditary basis. But he



recommended psychological treatment, not drugs or other physiological therapy.

Freud states much more positively that psychoneuroses have a psychological origin and can be psychologically treated. His remarkable theories and his technique of therapy for neuroses stirred the world as no other psychologist before or since has stirred it. According to Freud all persons have childhood sexual complexes, with minor conflicts and repressions. But these are handled satisfactorily by normal persons. Neuroses result when the entire energy of the individual is concentrated on oneself or on one's parents or when the delicate relation between Ego, Super-ego, and Id gets out of balance, resulting in serious conflict. The frustration becomes very acute when the demands of reality become excessively severe. Psychoanalytic treatment frees his mind from such fixations and tries to build up the Ego until the patient can cope with the problem. By dream-analysis and by free-association the analyst comes to understand the inner conflicts of the individual. When the patient comes to accept the interpretation of his trouble put forward by the analyst he is on his way to recovery.

Alfred Adler, a disciple of Freud, broke away from him and set up a school of "individual psychology". He disagrees with Freud on the latter's excessive emphasis on sex and his distinction between the conscious and the unconscious. For Adler the basic urge is a striving for superiority. When this is thwarted, as often happens, the person feels inferior and an "inferiority complex" results. He then tries to compensate for this inferiority by asserting himself in other ways. If this compensation activity gains recognition, the inferiority feeling may be removed. If the compensation is ill-advised and anti-social, it constitutes the neurosis. Not sex repression, but thwarted self-assertion is the cause of neurosis.

The best way of treating neuroses, according to Adler, is to discover the "style of life" or the role which the patient adopted early in childhood, chiefly as a result of his position in the family. All this is duly explained to the patient, so that he understands his inferiority complex and the failure of his compensatory efforts. He then is guided toward goals more socially acceptable and more within his capacity for achievement.



Carl Jung, another associate of Freud who parted company with him, held that the unconscious is partly personal and partly collective. The collective part consists of inherited primitive or racial ways of thinking and feeling. According to Jung neuroses occur partly because complexes built up in childhood persist and partly because some present difficulty overtakes a person's capacity to adapt. To treat neuroses Jung uses free-association and dream-analysis. But he begins by studying the present problem and how the patient meets it.

Several other psychoanalysts have contributed to our understanding and treatment of neuroses. Otto Rank put forward what is known as "birth theory": the shock of leaving the womb and entering an unfriendly world is the basic cause of our emotional troubles. Neurosis is interpreted by Rank as a misguided attempt to return to the uterus or to obtain rebirth. Karen Horney, a psychoanalyst now practising in New York stresses the role of cultural influences. Conflicts and neuroses, she says, do not arise from biological sources or instincts, as Freud held, but they are produced by contradictions in our culture. For example we are taught brotherly love and unselfishness, but society and culture are always stimulating competition. Such conflicts and contradictions lead to neuroses. Because neuroses are bred by culture they are very much alike in all persons.

While studying conditioning in dogs, Ivan Pavlov hit upon an interesting discovery which he called "experimental neurosis". A dog was trained to salivate by being given food whenever a circle of light appeared. The same dog was shown an elliptical patch of light but was not fed and did not salivate. After the dog clearly differentiated between the circle and the ellipse, the latter was made more and more circular. When the two became identical, the animal's power of discrimination broke down. It salivated without restraint, barked, whined, and struggled to get out of the harness. The experimental conditions had placed so much strain upon the dog's ability to differentiate stimuli that it became neurotic.

J. S. Liddel and N. R. F. Maier have produced experimentally neurosis and disorganized behaviour in sheep, pigs and rats by changing conditions under which they ordinarily reacted. The

animals ran wildly, jumped violently, went into epileptic-like convulsions and then became rigid or passive as if in a coma. Such experiments cannot be performed with human beings to induce experimental neuroses but some experiments have been made recently on the effects of frustration. Kurt Lewin and his companions gave several nursery children toys to play with, observers rated their performances on a scale of constructiveness. The children were allowed to play for fifteen minutes, the toys were removed and they were given far more interesting toys. After fifteen minutes they were forced to play with the previous set of toys which were less interesting while they could see the more interesting toys placed beyond their reach. They felt frustrated and showed it by being much less constructive in their play. In Freudian terms we would say that their frustration caused regression to a more infantile level of behaviour. But critics argue that experimental neurosis is not real neurosis but a faked one, but even then such experiments give us valuable insight into the effects of frustration and symptoms of neuroses.

### QUESTIONS

1. Write a general description of the behaviour of a neurotic.
2. What traits of personality are found in a neurotic?
3. What are the general causes of psychoneuroses? Explain in detail.
4. Describe the main types of psychoneuroses indicating briefly their main symptoms.
5. Many people think that neurotics only imagine their troubles. Comment on this statement.
6. Distinguish between neuroses and psychoses. Do the former lead to the latter?
7. Describe some of the important theories about psychoneuroses.
8. What do you understand by saying that psychoneuroses are psychogenic? Discuss the contribution of Janet, Freud, Adler, Horney and Pavlov to our understanding and treatment of psychoneuroses.



## Neurasthenia, Hysteria and Anxiety State

*Neurasthenia*

Etymologically the term neurasthenia means nerve weakness but this derivation has to be ignored. In common usage the term denotes abnormal weakness and fatigue with numerous pains and aches but abnormal psychology must provide a more accurate description of its symptoms. Many psychologists prefer to treat it along with the anxiety state but modern approach is to treat it separately. Beard who coined the term used it to mean general weakening of the nervous system due to over-work and exhaustion. But present-day psychiatrists consider that physical exhaustion has not much to do with it but is itself a symptom of the underlying psychological disorder. The cause of this trouble is not over-exertion but prolonged emotional tension. Let us study its symptoms in detail.

*Symptoms*: Neurasthenic reactions are marked by chronic mental and physical fatigue. When stimulated and provoked the patient can exert normal physical strength but he does not habitually exert himself and if he normally does so he tires rapidly. He can concentrate his attention but he normally does not do so. His motives are weak and he is listless, distracted and indifferent. He has lost interest in work, in normal thinking and behaviour. The lay man attributes this condition to all sorts of external factors but the cause is not easily discernible.

Now it may be argued that physical and mental fatigue, loss of vigour and persistence, of power of concentration, loss of sleep and lack of refreshment after sleep, and the like are symptoms which may be present in any other disease or in many diseases, but in neurasthenia these *symptoms have no physical cause*, cannot be treated medically and must be treated psychologically. Even very small emotional set-back is most irritating.

The fatigue of neurasthenia is not the result of over-exertion as is commonly assumed. The history of neurasthenic

patients clearly shows that they never work hard or feel tired as a result of that hard work if they do it. That is why rest or long periods of idleness have no effect on them. Page rightly points out that their fatigue is selective. A few minutes' hard work or concentration of attention may tire them but they are not tired if they engage in a long discussion of their symptoms. Perhaps it is the distasteful work which tires them. It may be due to utter lack of interest and enthusiasm.

Besides this chronic fatigue both mental and physical the patient complains of a number of bodily ailments which are somatic because they are psychologically caused. He may have headache, stuffiness or heaviness of the head, indigestion, lack of appetite, pain in the small of the back, dizzy spells, hypersensitiveness to irritations. These symptoms and complaints are often used to avoid tasks to which he does not feel inclined or adjusted. Meals are tasteless and often prolonged because of lack of appetite. Sleep is often disturbed. Often the patient goes to sleep immediately on lying in bed but wakes up after an hour or so and then is unable to sleep. During the day he is listless, distracted and very sulky and irritable. He is a "blighter" in company.

He is acutely conscious of his ailments and takes pleasure in describing his symptoms to people around him. He is always seeking treatment, and runs from one doctor to another to get relief. Every medicine he tries brings him initial relief but he again relapses. He looks healthy and normal, and the difference between his normal health and his description of his ailments is striking to the annoyance of some and amusement of others, so much so that he earns the description of "enjoying poor health".

As a class patients of neurasthenia are unable to help themselves and enjoy life, they frequently annoy friends and colleagues because they are constantly complaining, they are self-centred and selfish, they have a sulky and depressing approach to life and work, and are a nuisance to people around them because they do not show any zest for group play and enjoyment. They expect too much from people around them



particularly from the doctor who is treating them. They would very much like to be coddled.

*Interpretation :* Originally neurasthenia symptoms were put down to nervous weakness, due to prolonged conflict and over-work or to nervous exhaustion which involved long periods of complete rest and relaxation for the patient. Strong tonics, nutritious food, change of environment and the like were recommended and often made a difference in the condition of the patient. Some people attributed it to unsolved sexual problems and even to masturbation or sexual excesses. The patient usually attributes his trouble to bodily aches and pains, and thinks that he would recover as soon as these pains and aches are removed by medicines. He may even insist that he is suffering from nervous breakdown brought about by prolonged heavy over-work and fatigue. If that were so such patients should be clearly benefited by rest and relaxation, but a study of case histories has shown that they were not engaged in heavy work prior to the onset of this trouble nor has rest and relaxation any effect on them.

At present most of the psychiatrists and psychologists look on neurasthenia as 'a purely psychological trouble and regard their symptoms as psychological fatigue reactions. Prolonged emotional stress, complete discouragement, loss of enthusiasm and the like convert normal weariness and fatigue into chronic fatigue reaction. All those who are compelled to work under conditions which breed boredom and discouragement know how tiring and depressing their experiences can be. All these symptoms are just mechanisms to withdraw, they seem to be saying that the individual does not wish to participate in the game any more. The chronic fatigue enables him to escape the rigours of arduous tasks. He exploits his symptoms for personal gain, at least to attract attention and escape work. This invalidism is very useful to him.

Neurasthenia is very common among nervous housewives who feel neglected by their husbands and frustrated and cheated by life. Such persons usually have had a very delicate childhood and youth and if their domestic situation is depressing and unhappy they develop neurasthenic symptoms of fatigue, head-

ache, depression or irritability. In many Hindu homes a housewife sees no way out if her domestic situation is unfavourable and makes her unhappy. There is no escape from her husband's family or husband's cruelty and neglect. In a way our culture breeds neurasthenia among women, some of them take to reading fiction, gossiping and the like but the helplessness of their lot, socially and economically, is impressed on them every moment of their life and they succumb to such symptoms.

*Treatment* : In the first place it is well to recognize the frequently repeated fact that neurasthenic symptoms are caused psychologically and an essential item in the treatment is to enable the individual to gain insight into the nature and causes of his trouble so that it may be possible for him to revise his approach to life and its problems and to re-evaluate his goals and techniques with a view to regain a normal style of life.

Often psychologically induced bodily troubles involve organic defects or lead to such degeneration. The strain of the mental trouble on the physiological system certainly tells when it is prolonged. To that extent medical treatment will help and may be called for.

However, it must never be lost sight of that neurasthenic reactions are very obstinate because it is not possible to give relief to the life problems and difficulties of the patient. When the trouble is psychological the treatment will have to be long and the people around the patient shall have to be very patient and persevering.

### *Hypochondria*

In some people neurasthenia may lead to hypochondria in which condition they are obsessed with the thought of an organic disease that medical examination finds to be non-existent. They are over-concerned about their health or the condition of their bodily organs. Hypochondriac symptoms are very common with people in their forties and fifties and more frequently in women than in men.

*Symptoms* : The symptoms of hypochondria are very much



similar to those of neurasthenia. Excessive concern for one's health is one aspect of general abnormal interest in oneself. Often their complaints are very general as weakness of lungs, heart or muscles, disorders of stomach, funny sensations in the head or bad throat and the like. They are not very definite about their sensations and may confuse sensations of pressure, pain or heat in describing their ailments. They are always looking out for new complaints to which they may be subject or which they may claim, and they are avid readers of books and magazines on health and disease. Some of them may feel that they are suffering from every disease about which they read or hear. But they are generally ignorant about medical pathology.

In their anxiety to recover from their supposed disease or to build up strong health they are always taking medicines or following some dietary. They are sure that they cannot recover, that their complaint has not been correctly diagnosed or that doctors are more interested in their fees than in the recovery of their patients. They may also be pestering their friends and relatives about their complaints either by writing or in conversation. Hypochondriacs are greatly pre-occupied with processes of digestion and elimination; they may be very well informed about some new cures or ideas in the treatment of digestive or bowel complaints. They may be using laxatives and digestives indiscriminately, some of them are faddists in diet and certain methods of regimen.

*Interpretation :* Interest in our bodies and health is very common and is demonstrated by the large number of books and magazines published and sold on this subject. But the hypochondriac takes an exaggerated and abnormal interest and has an excessive anxiety and concern about his bodily health. It may have been that they started taking interest in health, physical fitness and the like very early in life but this interest took an exaggerated form in hypochondria due to disappointing experiences in later life. His professions of illness offer an escape from feelings of failure and disappointment. The anxiety produced by them is transferred to his body and health. It also gratifies his craving for worth and importance for the attention he gets from doctors and family helps to compensate for feelings of failure



and inferiority. He often succeeds in impressing others and controlling their behaviour by making a display of his medical knowledge and information.

The pre-disposing factors for hypochondria are parents having hypochondriac reactions, parental over-anxiety for the health and bodily well-being of children and early illness or injury. It is a commonplace that children imbibe the attitudes and ideas of their parents. When parents show excessive concern for their children's health even if it is just a sneeze, a minor bowel irregularity or a vague pain in any part of the body, children are persuaded to acquire an abnormal interest in their health and bodily condition which may later develop into hypochondriac reactions. And children are not slow to see that any bodily complaint gives them power over other members of the family and they, therefore, exploit every slight injury or pain to wield that power. Finally, children with history of illness or injuries learn to make too much fuss about themselves and when in later life they are faced with any stress situation they revert to those reactions which give them an opportunity to escape onerous tasks and gain attention besides. Extremely disappointing situations and failures precipitate hypochondriac reactions.

A definite type of personality is usually associated with such hypochondria. The individual may have ordinary social contacts, but psychologically he is found to be completely isolated, to be interested only in himself, without any sympathy with others. Some psychologists are inclined to place all diet faddists in this class, all those who take mineral water, avoid tea or live on nuts and milk or cabbages. Only some of them are hypochondriacs, most of them are just victims of other people's fads and fancies.

*Treatment* : The treatment of hypochondria is usually difficult because the patient does not easily establish rapport with the psychiatrist. Besides it is difficult to convince him that his complaints are the result of psychological factors and that his symptoms have been brought about by him with a definite purpose. He clings to his symptoms and resists any attempt to make him admit that they are not what they seem. In fact he has to



believe in those symptoms if he is to escape the stress situation, as that is the only way to escape facing his problems. That is why patients of hypochondria fail to continue the treatment. They listen to the doctor as long as he agrees that their symptoms are real and that he must prescribe some medicine for them.

Psychoanalysis and long interviews are necessary to get at the root of the trouble and make the patient understand that he is not really ill.

### *Hysteria*

The word hysteria is derived from the Greek word meaning "uterous" or womb. It was thought by Hippocrates and other ancient Greeks that this disorder was restricted to women and was caused by the wandering of a frustrated uterous to various parts of the body because of its strong desire for children. Hippocrates held that there is a close relationship of hysterical symptoms with sexual difficulties and thought that marriage was the best remedy for this complaint. This belief has now been abandoned. Today we know that there is no specific causal connection between the uterous and hysterical disorders and these conditions are common to men as well as to women.

Broadly speaking, hysteria is a mental disorder which is marked by dissociation, that is, the several mental systems of personality instead of working together in integration begin to work independently of each other and the personality is split into separate and independent parts, that is, it is dissociated. One mental system may develop incapacity of any bodily function without the knowledge of the other mental systems so much so that the patient may become blind, deaf or paralysed in any other limb and this flight into incapacity is spontaneous just to avoid or adjust to stress and difficult life situations. The loss of function may be mental or physical and it produces an acceptable retreat from the anxiety producing conflict situation. When the loss of function is prolonged or chronic the patient is seeking a permanent way or style of life in which the patient maintains his symptoms and lives and moves in situations to his liking.

*Types of hysteria* : There are three main types of hysteria.

In the first type the patient displays what are known as *hysterics*, that is, outbursts of uncontrolled emotion, often of weeping and laughter. In the second type there is morbid fear of harm to oneself. It may be general anxiety of some disaster happening at any turn or a localized fear of dark places, high places or lonely places. This is called *anxiety hysteria*. The third form of hysteria is called *Conversion Hysteria*, in which failure to meet the demands of stress situations ends in a breakdown of the central nervous system and the individual feels no pain or his limbs are paralysed. It was so called by Freud because a mental conflict was converted into physical symptoms. In situations of conflict and stress the patient, instead of having a purely "psychological" symptom, shows an observable change in an organic function. In other words, the "psychological" conflict is "converted" into a bodily disturbance.

These three types of hysteria differ so widely in their manifestations and symptoms that it is difficult to understand why they are being placed in one class. Persons suffering from hysterics are very much different from those suffering from conversion hysteria; hysterics are highly emotional and express their emotions in an unrestrained manner while patients of conversion hysteria are altogether indifferent and unemotional. It is because the latter have converted their emotional conflicts into bodily disorders. Apart from their utter lack of emotion and bodily disturbance the patients of conversion hysteria are quite happy and look normal. The leg or arm is paralysed but there is no other symptom because the mental trouble has thus been suppressed. Thus both are types of psychoneuroses. Here we shall deal with conversion hysteria in detail, and make only a brief mention of the other two types as their symptoms are being treated separately.

### *Hysterics*

People in hysterics have outbursts of uncontrolled emotion such as grief, panic, rage, fear or attacks of weeping alternative with laughing and other signs of emotional instability. Hysterics depend on faulty early training in which young people were not taught to control and restrain their emotions. Emotions



of such people are often unreasonable and they indulge in hate, jealousy or hunger for affection in a very unreasonable manner and degree. These emotional outbursts follow a period of suppression when emotions strongly aroused are kept in check until it is difficult to check them any longer. Many people in throes of anxiety on hearing good news have attacks of hysterics when they give way to weeping and laughing. Some students hyper-anxious to know their result in examinations on knowing that they are successful have hysterics in which they give way to tears and smiles. Another instance of hysterics is that of a person who laughs on receiving sad news. It may be that the grief is unbearable and has to be suppressed, and the individual seeks shelter in laughter. Some women have hysterical fits when they suffer from spasms and convulsions. Treatment of such cases must begin with understanding of the underlying cause, and helping the individual to build up strong inhibitions of intense emotions.

### *Symptoms of Conversion Hysteria*

It is common to distinguish between physical and mental symptoms but such a classification is of no importance considering that both mental and bodily symptoms are manifestations of one psychoneurotic disorder. But it helps better understanding of the subject and we may enumerate them accordingly.

Physical symptoms may be sensory such as—

1. Anaesthesias or loss of skin sensitivity to touch, pain or temperature. It is usually restricted to hands, a part of the foot or one half of the body.
2. Paresthesias or disturbances in sensation including tingling sensation.
3. Impairment of sight, blindness, blurring of vision and the like.
4. Disorders of ear, from difficulty of hearing to complete deafness.

Or there may be motor disability of one type or the other such as—

1. Paralysis of one or the other part of the body, like the leg or the arm.
2. Astasia, abasia or disability to stand and walk though the patient is able to move his legs while lying in bed or sitting.
3. Spasms, convulsions and tremors.
4. Loss of voice and stuttering.

Or other physical disabilities like excessive sweating, blushing, vomiting, loss of appetite and cramps.

These physical symptoms are just like organic defects but they are psychologically caused. In hysterical deafness, blindness and anesthesia, messages are sent in a normal manner to the cerebral cortex but somehow they are not registered. There is no physical disorder but somehow the motor and sensory organs do not work. It is not easy to recognize that these physical disturbances are caused by mental or psychological factors, and many people put them down as imaginary or unreal. But they are caused by mental conflict and serve a definite purpose. A medical student who faints on first handling a dead body in the anatomy class is able to get over his nausea and disgust by fainting. Many people faint on hearing shocking news. Here fainting is a protective device which helps to avoid violent emotional reactions and thus softens the blow.

The mechanism is the same as has been indicated above. When an individual faces an intolerable situation involving great emotional strain he develops physical disabilities which in a way protect him from that situation or offer him a way of ready escape. Blindness, deafness or paralysis will serve to save the patient from the disagreeable situation. What symptoms he will develop will rest mostly on his past experience. If he sustained in the past a leg or arm injury he is more likely to develop leg or arm paralysis. But it should never be understood that he is faking or imagining. He is really paralysed, the cause is purely psychological and the process of incapacitating is entirely unconscious. The benefit the patient derives from his symptom is entirely unwitting. Because he gets sympathy and a sense of



worth from his symptoms he is naturally not at all interested in knowing their cause.

The major mental symptoms of hysteria are loss of memory and personality dissociation. A common thing to happen is to forget one's own identity. This is a form of *amnesia* and the patient forgets his name, address, his family associations or even his life. But this amnesia is not complete. The patient may remember language, what to say on a particular occasion, his manners or other things of impersonal character. Almost all cases of hysterical forgetting are made worse by disappointments in love affairs, family quarrels, financial loss and the like. The patient unable to tolerate the pain or shock of some memory sub-consciously seeks to escape through forgetting. Such an escape is temporary and when after a few hours the patient recovers from the shock memory gradually returns. Page quotes a case of a married woman who asked a policeman to take her home as she did not know who she was and where she lived. She was taken to a hospital where under a sedative drug she told of her unhappiness in married life and love for another man. She had finally asked her husband for a divorce and had made an appointment to discuss the matter with him. After waiting in vain for two hours for her husband to appear, she wandered off and lost her memory.

*Somnambulism* is another neurotic reaction found in patients of hysteria. Lost ideas and memories are dissociated from the main current of personality or conscious life and though blocked off they are strong enough to determine the patient's behaviour, if not in waking life, then in sleep. This may be considered a secondary personality and the patient not only walks in sleep but also performs a number of tasks which require intelligence and intricate adjustments. The author knows of a person who would get up at night in summer, roll his bedding, carry it indoors, take a glass of water, again carry his bedding and throwing it on the cot would go to sleep. In the morning he would wonder how he was sleeping with his bedding rolled. He could not recall anything that happened during his sleep. Psychoanalysts hold that the behaviour of a somnambulist is just a re-enactment of emotional experiences which have been cut away or dissociated from personality.

In rare cases the desire to escape an intolerable situation and its emotional tensions takes the form of what is called *fugue* which is a French word for flight. In addition to forgetting his past life and identity, the patient runs away from home and starts a fresh life in a new distant place. Fugue is another form of amnesia in which while the past life is forgotten the other abilities of the patient are unimpaired and he appears normal to all those around him. Obviously the fugue is also a dissociative reaction in which the individual leaves his present life and sets up an altogether different mode of life in an absolutely different environment. Fugue is also a defence reaction by flight : the patient wanders away from home and for days, weeks or even years may not at all remember what he is, where he comes from or how old he is. It is complete forgetting of the past though all the abilities remain normal. Then suddenly he finds himself in a strange place, not knowing how and why he came there.

In all these states of amnesia the pattern is the same as in amnesia of conversion hysteria except that in conversion hysteria the patient gets rid of the intolerable situation by getting sick or developing disability or paralysis, and in these states he simply runs away from the situation and forgets all about it adopting a new mode of life and work.

By now readers must have understood that the patient of hysteria leads two lives, one life is altogether unaware and ignorant of the other and there is no impairment of the behaviour traits and abilities. Much more dramatic is the phenomenon of *dual personality*. This is also a hysteria reaction and the individual passes from one life and personality to another with ease and much more quickly. At one time he may be one type of person and then quite another, and in this alternation of personalities his two spheres and types of behaviour are totally different and separate. One self does not know what the other self was doing some time before. Practically all recorded cases of dual personality belong to the past and there is no mention of any cases occurring these days.

All normal people experience moral conflicts, their good moral tendencies revolting against their vicious, bad temptations.



Most of them are able to resolve such conflicts and integrate them into their personal make-up. Often some very good people allow themselves to behave in a manner which surprises their close friends, but even then on the whole their personality and behaviour reveals a consistency and harmony and seems to be well-integrated. Hysterical individuals lack this integration, cannot harmonize their conflicting tendencies and are unable to obtain any uniformity or consistency of behaviour which is a manifestation of emotional stability and mental equilibrium. They are then controlled by two distinct mental systems alternately resulting in two separate and independent personalities. These two personalities are self-contained and self-sufficient, they have a memory system of their own and are self-governing. The transition from one personality to another may take place during sleep or even in waking state. The personality in charge of the body at any moment may disclaim any knowledge or responsibility of the doings of the other personality.

In some very rare cases instead of two there may be *multiple personalities*. The underlying mechanism is the same only the individual is split into not two but more than two personalities.

#### *Personality traits of hysteric patients*

People who suffer from hysteria are generally simple, naive, unsophisticated, credulous, suggestible, unstable, self-centred and emotionally unstable. They have not had any adequate affection and attention during their early years and crave for them now. They often replace logical arguments with immature, childish emotional responses. Their behaviour is inconsistent and impulsive. In frustration they resort to temper tantrums, and when shocked they display contradictory reactions of weeping and laughing. They are not strong-minded but have strong loves and hates which alternate. To obtain their ends they often hold out threats of suicide. Their imagination is vivid and their reactions are generally quite dramatic. They are generally not highly educated though hysteria has been found among well-educated people. When well-educated people suffer from hysteria one may conclude that very great damage has been done to personality. Generally the I.Q. of the hysteric is lower.

*Interpretation*

In conversion hysteria the individual avoids or solves some problem by getting sick. Generally what happens may be that there is a desire to escape some intolerable situation, a fleeting wish or thought that if he were sick he could escape it well enough, and with greater stress the symptoms of some illness do appear. The wish is suppressed by symptoms of the bodily ailment and these symptoms replace the wish, and the patient sees no relation between the suppressed wish and the symptoms of the stress situation.

The hysterical illness represents an attempt on the part of the patient to remove himself from an unpleasant situation, to regain lost social status, to escape feelings of guilt and self-punishment, to secure revenge for alleged harsh treatment or cruelty. In some cases hysterical illness follows some accident or injury for which the patient may get some financial compensations. But it is difficult to distinguish between actual malingering and the unconscious deception of the hysterics.

*Treatment*: Patients of hysteria resist treatment and do not really co-operate with the psychiatrist. Magical cures often reported are due to strong suggestion. Hypnosis and narcotics have proved helpful in addition to psychotherapy which will be described in detail later.

*Anxiety state*

This is the most common of the various kinds of neurotic disorders and occurs mostly among individuals of above normal intelligence. Its chief symptom is free floating diffuse anxiety which does not seem to arise from any particular situation or object. In a way all types of neuroses involve anxiety of extreme intense degree but in this disorder anxiety is not unconscious or suppressed but on the surface to be observed by everybody.

*Symptoms*: There is mild chronic anxiety which now and then becomes acute for a few minutes to a few hours. These spells of anxiety usually come all of a sudden and increase to great intensity and then subside. There may be general fear, gloomy



forebodings, fear of dying, feelings of insecurity and general excitement. Patients have palpitation of heart, tremors of hands and feet, difficulty in breathing, sleeplessness, excessive perspiration, indigestion, fatigue and depression of spirit. The patient feels that some serious calamity is going to happen to him. Some people feel all sorts of pains and aches, headache, emotional instability or inferiority. There may be dizziness and the patient may totter.

Although he feels relatively normal in between attacks of anxiety there is tension and persistent mild anxiety which may at any time burst into acute attacks. There is general loss of interest and the patient is unable to concentrate attention or think properly. And even if things are going on fairly satisfactorily their anxiety persists and they go on feeling nervous and giving advice to people around them. This continual anxiety interferes with their efficiency and they are not able to apply their mind fully. They go out of their way to find things about which they must worry. They are a source of great inconvenience, and even nuisance, to their friends and relatives because they see misery and uncertainty where none exists, and serve to spread it to others. Between attacks most patients are relatively free from anxiety and worry. But a good many start reflecting on the mistakes they made or thought they made. When they are not worrying about the past they are worrying about the future. When they sleep they have anxiety dreams such as being pursued by murderers, being shot, choked or thrown from high places. Such anxiety dreams may awaken them only to start them on reflecting about depressing events.

Because of their high tension and a feeling of strain patients of anxiety state are always over-reacting to minor difficulties and thereby adding to their anxiety and tension. This is shown even by their straight posture and hurried movement, loss of appetite and sleep and difficulties in concentration.

*Interpretation :* Case histories of anxiety state patients reveal that they always have a feeling of insecurity and inadequacy, suffer from utter lack of self-confidence and fear about their ability to achieve their goals, to meet the challenge of their social environment or face the difficulties of

life and the world. Modern life is full of competitive spirit ; there seems to be a race on for everything and in every area of life and work, and this adds to the difficulties of most of us who are always feeling uneasy about their place in this world and their future happiness. And even without any outside provocation most of us have extreme anxiety reaction. We consider all events in their dangerous possibilities and this often leads to anxiety and self-devaluation.

One of the most powerful factors pre-disposing a person to anxiety state reactions is emotional insecurity and extreme sensitivity even to the slightest defeat or threat. Many people who have known great emotional insecurity in childhood due to poverty, neglect, loss of parents and the like work very hard in adult life and may succeed. Still they never feel easy or secure, are assailed by all sorts of threats and dangers and lead a life of anxiety and nervousness. And if they set themselves too high standards, their cases become worse. Many people acquire this insecurity and neurotic anxiety from their parents. Early childhood experiences contribute a good deal to the development of anxiety state reactions.

Or it may be that there have been tragic events in later life like disappointment in love, financial loss or breakdown in family relations, and they may have left a strong base for building up an anxiety state. Thus anxiety state reactions are often an aftermath of very unfortunate experiences. Or sometimes the life situations of an individual are such that they breed anxiety state reactions but they do so when chronic mild anxiety is already present. But the patient never sees the relation between anxiety reactions and the particular threat. We may list some of the threats from life situations :

(a) The most important threat comes from fear of loss of status or position. Neurotics are very sensitive about their moral worth or social importance, and those who are over-sensitive about it are over-ambitious, conscientious, active, energetic individuals who have always worked hard and worked their way up by sheer diligence. Such people have had early insecurity and experienced deprivation, loss of affection by the death of one or both parents or neglect in the home. They have strong



inferiority feelings and are very much afraid of failure and defeat. They work hard to avoid it and often overdo things. They seldom relax and have no time or interest for play or recreation. They develop anxiety symptoms of very distressing nature.

Recently psychologists have made detailed studies of cases of people who lost one or both of their parents early or were deprived of the help and protection of individuals on whom they depended for their safety and protection. Some of them were over-protected by their parents and with the loss of parents felt quite at sea. A widow with an only son may have anxiety attacks as she sees the threat in her son marrying and leaving her. Many sons are compelled to postpone marriage for the sake of their widowed mothers.

(b) Dangerous desires of immoral sexual nature or hostility to people whom we love may break through our behaviour and hold out serious threats to our moral values, social or economic status. Most often they are suppressed but there is threat of their breaking through, and they produce strong feelings of guilt about immoral sexual behaviour or the possibility of it. The anxiety is produced by the conflict between the desire for immoral behaviour and the feelings of guilt at the thought of it.

(c) Another important factor is unsatisfactory life situations from which the individual finds no escape. So he or she remains tense and anxious. Some of them find compensation by gratifying sexual desires. Incompatible marriages, domestic quarrels, a job in which there are no opportunities for self-expression or which one does not like and which one cannot give up either, puritanical training and marriage to a happy-go-lucky person and the like make life intolerable, unbearably dull and drab, and produce tension, restlessness and anxiety which any serious mistake, accident or misfortune may aggravate into neurotic anxiety state reactions. These symptoms are common among dependent, emotionally immature married women, mostly of the middle age who were pampered and spoiled by parents but are now unable to get the same solicitude and attention from their very practical and matter-of-fact husbands. Many husbands are undemonstrative and are unable to give them such pampering as they received in their parents' home. Their wives are bound to feel

neglected, insecure and lonely. Many of them are not in good health and such treatment at the hands of their husbands makes them irritable, tired and depressed. They may develop some neurotic illness which may win them their husbands' attention and sympathy.

*Treatment* : Neurotic patients suffering from anxiety state respond well to treatment, although their general anxiety is seldom removed. Anxiety is frustrated fear and if the cause of fear is removed it may to some extent relieve anxiety. When his anxiety is reduced an attempt should be made to motivate him for satisfactory adjustments to life, to give him worthy goals and provide strong incentives for pursuing them. Most of us have to live with anxieties, to face stress situations and to meet the challenge of difficult situations which threaten us with loss of status or happiness, and all that can be expected is to reduce as much of anxiety as possible without attempting the impossible task of eliminating it altogether.

### QUESTIONS

1. What is neurasthenia? Describe its symptoms and the causes which lead to such a neurotic state.
2. Describe the symptoms of the several types of hysteria and indicate what traits of personality are favourable for the development of this psychoneurosis.
3. What is conversion hysteria? Why is it so called? How would you deal with a patient of conversion hysteria?
4. What is neurotic anxiety? What factors favour its development?
5. Describe the nature and symptoms of hypochondria. In what sense can it be described as a type of neurasthenia?
6. Describe a case of psychoneurosis you have known closely and describe his symptoms and the causes of his trouble.



## Other Forms of Neuroses

*Obsessive-Compulsive states*\*

Obsession means persistence in the mind of an unwanted idea, and obsessive state in abnormal behaviour means morbid and involuntary pre-occupation with some thought or idea. It is a persistent thought or idea which the individual recognizes as irrational but cannot get rid of. He has no control over such ideas, emotions or urges. It is a common experience even with normal people that at times they have a persistent tendency to think about something or to repeat over and over again to themselves the words or melody of a song. When this sort of thing is greatly intensified, it becomes an obsession and greatly disturbs the mental peace of the individual. Usually obsessions are concerned with questions which cannot be answered, they may be dealing with the nature of existence, God or truth, they may concern the future of mankind or one's own nation or they may be full of morbid doubts about the morality or otherwise of our past conduct. In the latter case the individual may be continually confessing his guilt to priests or his dear ones, but even such confessions do not give him any peace of mind.

Compulsions are irresistible impulses to perform some seemingly unreasonable act over and over again such as hand-washing, counting money, dusting things, tics of the face, sign-reading, pole or step counting and the like. It is difficult to separate obsessions and compulsions, we can only distinguish between them in thought, because obsessive ideas often issue into compulsive acts, and compulsions are based on obsessions.

In obsessive-compulsive reactions the patient recognizes that his behaviour is irrational but seems compelled to think about something that he wishes not to think about or to carry out actions that he does not want to carry out. Obsession and compulsion are parts of the total reaction pattern.

*Symptoms :* It has been pointed out above that normal persons too have obsessions and compulsions, they are unable to resolve their doubts and turn them over in their mind again and again. Many of us after carefully locking all doors at night and getting into bed are assailed by the doubt if they have done it satisfactorily, get out of bed and check all doors again. Many of us while getting ready to go out for shopping check and recheck money in their pocket and make sure about it. But after checking we feel reassured and go to sleep or walk out of the house. But the abnormal person suffering from obsessive-compulsive reaction will check doors again and again or count his pocket money again and again and still feel doubtful. He may check them 50 times and still feel restless till utter exhaustion sends him to bed or forces him to go out. There is nothing to reassure him as his doubts are a mere manifestation of his inner trouble, of an unresolved conflict.

These reactions are very disturbing and painful because the patient fully realizes that they are absurd and meaningless but he is powerless to check or fight them. He would very much like to get rid of them, and in his own way tries his best to do so, he is unable to resist either the obsessive thought or the compulsive behaviour to which they lead. His entire life and behaviour is dominated and restricted by these symptoms. Such obsessions and compulsions lower the effectiveness of the individual's adjustment and spoils his peace of mind. A normal person may have similar doubts and misgivings but his adjustments and peace of mind are not upset by his persistent thoughts and urges. On the other hand the neurotic feels extremely restless and tense when he has persistent thoughts, his anxiety is overpowering, and he seeks relief by yielding to his impulse to wash his hands, check his money or examine the locks of doors. But this relief is only short-lived. A few minutes later he again has a strong and persistent urge to repeat his behaviour.

Because he is compelled to repeat his actions he wastes a good deal of his time and energy, and is unable to attend to other important things. The patient who is obsessed with the



mania of cleaning and washing hands will do it fifty times per day and still feel inclined to do it again, the housewife who is obsessed with the idea of dusting furniture will go on doing it again and again to the neglect of other important duties in the kitchen. The accounts clerk who is obsessed with the idea of making mistakes in totalling will total them again and again and still suspect that his total is not quite correct. Many women take lot of time getting ready for a social function, they may be dressing their hair many times and still feel very diffident about their appearance and they may take still more time to select what dress they must wear. Such people lose much time and energy in their obsessions and must be finding no time for other important things.

Some of the obsessive-compulsive states are really anti-social and harmful. Some people feel an irresistible desire to pinch certain things from other people's homes. This is called *Kleptomania*. Some people feel an irresistible desire to set fires. This is called *Pyromania*. Obviously, such obsessions-compulsions have legal consequences and the patient does not derive any benefit from them. He has no use for the stolen things and he steals only to relieve his inner tension just as the pyromaniac sets fire to other people's things not to take any revenge but only to satisfy his inner urge.

*Interpretation* : Obsessive thoughts may be serving the purpose of keeping other thoughts, more unpleasant, embarrassing and distressing out of consciousness. They change them into unconscious impulses. There is a friend who washes his hands before meals like everybody else but goes on washing for about fifteen minutes till his attention is drawn to this fact, before he takes his seat he takes out his handkerchief and wipes the place where he is to sit, he takes much longer in the bathroom, when the washerman brings washed clothes he puts them out in the sun for getting them disinfected as he says, he would wipe his plate in which he is to eat his meal or clean the cup in which he is to take tea. His obsession for cleanliness obviously serves to hide, to change into unconscious, his feelings of guilt or other unpleasant and distressing thoughts and memories. A detailed study of his history shows that as an officer of the government

he made lots of money through unfair means and bribes. These ideas and memories are now thrown or pushed into the unconscious by obsessive-compulsive behaviour of keeping clean.

Usually such people are highly nervous and if they have been cruelly treated in childhood or have been very strictly brought up the disposition to obsessive-compulsive behaviour increases. Some of them may not have received adequate goodwill and friendship from their colleagues or may have been frequently snubbed by their superiors. Or in their early training undue stress may have been laid on cleanliness, duty, punctuality or etiquette. Or it may be that they were goaded on by some unscrupulous member of the family.

Obsessive-compulsive reactions may grow out of feelings of guilt and self-condemnation because of desires which are not morally acceptable or behaviour which is forbidden. The person is terribly afraid of the social consequences of his behaviour or of the possible punishment for immoral desires or wishes. In the above example the person has feelings of guilt, has condemned himself and continues to wash his hands and the like as an atonement or expiation for his past conduct. At the same time the obsessive thoughts and compulsive behaviour is about the only way he can protect himself from the world which he sees as threatening his existence and social status. Washing his hands to an excessive extent seems to be the only way he can make satisfactory adjustment to the world, and relieve his anxiety and feelings of guilt.

Thus compulsive acts are defence reactions to obsessive thoughts and fears. Mild forms of compulsive behaviour such as mopping one's forehead, licking one's lips or pulling one's nose or chin are performed under stress and are such acts as the individual has learned to perform to relieve tension. As Page says : "Obsessive-compulsive symptoms are best interpreted as protective devices designed to absorb and neutralize the anxiety created by inner conflicts".

#### *Personality traits of obsessive-compulsive reactions*

People disposed to obsessive-compulsive reactions are nervous, sensitive, intelligent enough to compensate for their inability to



take decisions and their feelings of insecurity by being excessively clean, orderly, particular about details and over-conscientious. They want to be accurate and perfect in everything they do. They arrange their time-table of daily routine very carefully and follow it very closely. They take their meals at a fixed hour, expect their guests to be very punctual, pay their bills promptly, expect nothing to be shifted in their household and frame rigid rules for those who work with them. They are intolerant of other people's weaknesses. They are mostly introverts and are not able to develop cordial relations with others.

### *Phobias*

Phobias are intense, irrational and absurd fears. Persons suffering from phobias know that their violent fears have no basis but they cannot explain or overcome them, they realize that the object of which they are afraid does not present any actual danger but they are unable to help their phobic reactions. We may list some of the major phobias :

- |                   |   |
|-------------------|---|
| 1. Acrophobia     | Fear of high places                       |
| 2. Agrophobia     | Fear of open places                       |
| 3. Astrophobia    | Fear of storms, thunder, lightning        |
| 4. Claustrophobia | Fear of closed places                     |
| 5. Hematophobia   | Fear of blood                             |
| 6. Mysophobia     | Fear of contamination by germs            |
| 7. Monophobia     | Fear of being alone                       |
| 8. Nyctophobia    | Fear of darkness                          |
| 9. Ocholophobia   | Fear of crowds                            |
| 10. Pyrophobia    | Fear of fire                              |
| 11. Zoophobia     | Fear of animals or any particular animal. |

Some people are excessively timid and cautious when they are climbing a tower or looking down from a high place, meeting a barking dog or spending a night alone. But such fears cannot be described as phobias. A phobia is a pathological or morbid fear. It differs from intense normal fear in being more violent and paralysing, in the situation arousing phobia being not at all

threatening or dangerous, in the fact that the individual accepts and recognizes that his fear is baseless, irrational and absurd while the timid and cautious holds that his fear is justified, in the individual having no control over his phobia, and in the difficulty of removing phobias.

We have tried to list phobias but this list is not exhaustive. There are phobias pertaining to dirt, knives, death and what not. Nor is this classification of any help in understanding or explaining phobias. The names and the list are purely descriptive. Fisher, therefore, groups phobias into three heads according to the psychological origin of the phobia. He mentions three classes of phobias: *simple concrete phobias*, *symbolic concrete phobias* and *symbolic abstract phobias*. In simple concrete phobias the patient is afraid of any simple concrete fact in its literal meaning. It has its origin in some simple actual fear in which that particular fact was experienced. One of my own family had phobic reactions to pigeon's feathers. Children knew about it and often made fun of her to her great chagrin and terror. It so happened that in her very young days she once saw a pigeon being caught by a cat and screamed in great terror but she forgot about it and the fear remained. Her fear was so violent that she would grow pale and even sweat, and other members of the family had to come to her help and reassure her. It was years later that she got used to birds being killed by her husband when out hunting that she gradually lost her phobic reactions. Such simple concrete phobias always have their origin in some concrete fear experience.

In symbolic concrete phobias the object of which the patient is afraid is symbolic of some other experience or meaning. A person may have phobic reactions about a knife, a swastika sign, or a paper because that sign may symbolize some frightening experience in the past. The knife may stand for murder, the swastika sign for political tyranny and the paper for some sort of legal blackmail.

In symbolic abstract phobia his fear is undifferentiated and because of prolonged frustrations or failures he shuns any participation in his environmental activities. It may be that he has acquired it from his parents this phobia of the environment



and he is so much in conflict with it that he either enters into his activities mechanically and listlessly or has developed a reserve or restraint and frequently disparages all around himself. It is generally the case with people who meet too much frustration in daily activities and their egoistic reserve hardens.

*Symptoms :* Most of us are afraid of things of which we normally should not be afraid, our fears are irrational, baseless and uncalled-for. But phobias are very intense and violent fears and interfere with the daily activities of the patient. Thus a person suffering from acrophobia may go out on trips with other people but avoids climbing high places, mountain tops and the like. Even if he or she does climb, he or she simply refuses to look below and survey the scene in the plains. Many of them may live in the upper storeys of a sky-scraper but will avoid looking below on the street. They are terribly afraid of doing so. Such people do accept that they have no cause to be afraid, and that their anxiety is absolutely uncalled-for but they say that they cannot help themselves. This fear and anxiety may be mild uneasiness or a full-fledged anxiety attack.

Other symptoms of phobic reactions are neurotic headaches, pains in the back and limbs, dizzy spells, disturbances of digestion, feelings of inferiority and even obsessive-compulsive reactions which have been discussed in this chapter.

*Interpretation :* The diagnosis and treatment of phobias is possible only after the underlying causes of phobic reactions have been understood. The general rule of psychoneuroses applies here too that phobic reactions are essentially attempts to meet danger from inside or outside, they are simple defence reactions, that is, protective devices to which a person has to resort to avoid threat and anxiety.

Usually such patients have traumatic experiences in early childhood and phobic reactions are outgrowths of simple conditioned fear reactions. As a child one of the family was pushed from the housetop in his village, he was not seriously hurt as the ground below was soft but he had such a fright that he developed fear of high places. Another person is very fearful of taking bath in a river. In his young days he was a useless spectator of a drowning tragedy in which his brother was



involved. Such shocking experiences developed in them phobic reactions toward particular types of situations.

Case histories of phobia patients have revealed that some of them have parents suffering from phobias. A father who is terribly afraid of cockroaches is most likely to strike a similar phobia in his children. A mother who feels terror when there is lightning and storms, and expresses her protective impulse towards her children by hurriedly taking them inside whenever there is a storm and lightning is sure to teach phobic reactions to her children. Most people who have phobic reactions on meeting a dog have had traumatic experiences of dogs in their early life. They probably were terribly frightened and screamed when they saw a dog running, barking at them, the details of the terrifying experience were forgotten but the fear remained, and though they could not explain their irrational fear they pleaded that they could not help themselves whenever they saw a dog. Sometimes such situations or stimuli are generalized and the patient gives expression to phobic reactions even when meeting a bear, a cat or seeing wild animals in a zoo. The fact that they are locked behind bars has no effect on them.

As has already been pointed out some phobic reactions are symbolic and fear and anxiety are attached to symbols which represent actual situations in which they were originally experienced in a violent form. The school may become a symbol of the very humiliating and distressing experiences a person had there in his childhood and the tyrannical treatment he received at the hands of his headmaster or teachers.

Phobias may grow out of feelings of guilt and anticipated punishment. People who were trained and brought up in very strict homes full of puritanical atmosphere may live in continual fear about losing their morals if they indulged in any talk or behaviour related to sex. Their fear about sex may, if prolonged, become obsessive.

Phobic reactions may be used as a means of obtaining attention, sympathy and consideration of others, and the patient may use them to dominate his friends and relatives. But in most cases he is bound to meet with ridicule and fun as the



common people do not care to appreciate the difficulties of a neurotic and condemn him as a fake.

*Treatment :* The treatment of phobic reactions depends on the nature of the underlying cause. It is usually more difficult than that of anxiety attacks, particularly if the condition has lasted for some time. If it is due mainly to shocking experiences in early childhood, a carefully drawn up programme of reassuring him and bringing back to him the nature of experiences under which he acquired his phobia may help. Often he is encouraged sympathetically by friends and relatives to face the situation in which he feels terror, he may be persuaded to go up high places or face animals in a zoo and repeated experiences in these situations may help him to overcome his phobia gradually. Parents would be well advised that they should help children under their care to overcome the frightful aspects of shocking experiences and prevent the development of phobic reactions by discussing such experiences in an objective manner. Such persons need great care and sympathy and no useful purpose is served by making fun of them or laughing at their fears. Help of psychotherapy detailed hereinafter in some of the following chapters should be sought.

Patients of phobic reactions are generally not aware of the basis or origin of their fears, their reactions are often violent causing great inconvenience to themselves and people around. But if they are assured that their violent fears would disappear altogether they would willingly co-operate in the treatment and removal of such fears. In the case of strong guilt feeling being the cause of such phobias change of social environment and temptations to join groups of people for whom those taboos do not exist will go a long way to help.

#### *War neuroses*

The history of the world or any country is mostly a history of its wars and the conditions of warfare, social disorganization, separation from their dear and near ones, working in an organization which is extremely regimented and exposed to the horrors of modern combat, lead to several types of mental disorders. Most people crack under the strain and their personalities dis-

integrate. Such psychoneuroses as occur under stress of conditions of war were called *Shell Shock* in the First World War and *Combat Fatigue* in the Second World War. Both these terms are misleading as Page has pointed out because they wrongly imply that it was the physical effects produced by exploding shells or the fatigue of battle which were responsible for the appearance of the neurotic symptoms. But really it was the psychological strain of forced and continued living and working under terrifying and dangerous conditions, of harsh and cruel scenes and sounds, which precipitated the symptoms. During the Second World War psychologists began to talk of minor neuroses caused by working and living at the battle front as *war neuroses*. War conditions involve new types of situations for almost all people and both civilians and army men may suffer. Of course, both try their level best to make suitable adjustments in war situations but a number of them are unable to adjust adequately enough. We may draw up a list of probable sources of stress and strain :

1. The most basic hazard was the separation from the family and anxiety for the welfare of the family. This was especially true about those soldiers and civilians on the soil of whose country actual fighting took place. Russia, France and Britain were involved in the Second World War and the civilian populations were as badly bombed and mauled as the soldiers.
2. Fatigue. Anxiety marks physical fatigue brought about by bad food, long hours of work and difficult conditions of work and rest.
3. Rigid discipline which brooks no exception or deviation.
4. Boredom and monotony for both civilians and soldiers. No change or recreation kills the spirit.
5. Loss of liberty and abundance of restrictions on food, rest and talk.
6. Strange and unfamiliar surroundings. Sometimes they were disgusting.



7. Change of diet.
8. Radical change in attitude toward authority.
9. Radical change in the mentality of people—constant fear, threat and danger to life and property makes peace loving people wild with thirst for killing enemy.
10. Fear of injury, losing a limb, becoming deformed or even death.

Fatigue, anxiety and dangers of death or injury creates severe tensions and what were once efficient and effective workers are haunted by these and turn listless, dazed and inefficient. A number of persons whose adjustments were already less than normal and who had germs of psychopathology fall an easy victim to these disturbing influences of the new environment. Here we will deal only with the neurotic reactions of the army personnel.

Some people form their life patterns and goals fairly early and their patterns of adjustment are very rigid and inadequate. Such people are the first to break down in their military career. War involves new types of life situations, they are expected to give up certain goals and patterns of behaviour, to acquire new type of speech, to give up their individuality and merge themselves into a herd of killers of the enemy. They are called upon to identify themselves with the country to a much greater extent than they had done so far. Some are able to make suitable adjustments under the necessity of patriotic feeling but others feel nagged, frustrated and disgusted, always ill at ease.

The first experience of actual combat may exhaust him not only physically but also emotionally. His duty is intense, his failures involve feelings of guilt and depression. He may not be able to co-operate with others or participate in the life at the battle front. If this combat stress is prolonged and severe it may produce violent conflicts and lead to the breakdown of personality.

When the army personnel returns to civil life after the war they have to face new difficulties. Patterns of social life, employment and economic order change radically during the war and they are not able to fit into the new world readily and easily. Some of them are not able to satisfy their basic needs and

bring a hostile attitude from the war. This places them at the other end of their world and they may not be able to live in peace with it.

Many women entered war service for patriotic feelings. Some might be doing it for acquiring freedom and security of employment, but having to put on uniform, to give up their cosmetics and indoor habits and ways, their feminine roles and chores, to work under pressure, not seldom under the eyes of men, create conflicts and tension which spell neurotic troubles.

*Symptoms* : These are generally described as combat fatigue or operational fatigue involving irritability, loss of sleep and digestive disturbances. The people are easily startled and even when facing mild stimuli their reactions are violent and over-done. Even small annoyances easily develop into intense angers and the emotional control is impaired. A mild noise may make them jump and carry out defence reactions. In the face of overwhelmingly powerful and dangerous forces from which they cannot escape and which they cannot possibly halt the people feel extremely helpless and are assailed by anxiety states.

There may be symptoms of conversion hysteria and the limbs and organs affected are those which are needed most by soldiers in actual fighting. Such symptoms resolve the conflict of the soldier between his desire to run away and his need to remain and fight. If a soldier is wounded he arrives in the hospital tense and shaky, he trembles while speaking and he is afraid, but after his bandages are removed and he has had a look at his wounds, he feels calm and carefree for he now is assured a long escape from combat situations.

There may be phobic reactions, amnesia in which he forgets all about his experiences and friends, he may even forget his past history. Many soldiers run away from the battle field not merely to escape the danger zone but because they wander away having forgotten all about who they are and what they have been doing. In such cases their anxiety had become unbearable and they repressed all details and memories completely.

There are psychosomatic reactions in which several bodily organs are involved. Eyes and ears may stop functioning, there



may be digestive disturbances, abdominal ulcers, pains or even vomiting. Urinating and elimination may be uncontrolled or there may be palpitation. Anxiety and depression follow frustrations of prolonged and intense nature.

Some soldiers on being discharged from the army on the termination of the war become very passive and dependent on others.

*Incidence :* Incidence of war neuroses is not high at all mostly because new recruits are given detailed psychological tests and those with tendencies to neuroses are eliminated. Detailed investigations made during the Second World War have revealed that soldiers who suffered most were raw and had not been given adequate training or they belonged to defeated or retreating troops ; or their regiments had not been given frequent rest from the battle front or their morale was low. Some patients had no adequate armoury to fight back and were under fire they could not return.

*Treatment :* Methods of treatment are detailed in a separate chapter. In addition to those methods patients are given hypnotic drugs in sufficient quantity so that they feel sleepy but do not actually go to sleep. In this state of semi-consciousness they are able to revive their memories of shocking experiences and they are able to integrate their behaviour again. The aim often is to bring back such patients to active duty or other auxiliary duties of war.

### *Traumatic neuroses*

These psychoneuroses follow physical injuries or accidents. It is quite possible that physiological or neurological changes may not be present and such cases are dealt with independently of the physical factors. Such neuroses are seldom found among children, it is the mature adult, particularly the male, who is a ready victim. Page thinks that there are two critical indicators : (1) a marked discrepancy between the severity of symptoms and the extent of actual injury, and (2) resistance of symptoms to treatment.

The most important factor in the production of this disorder is obviously of objective nature, some shock, injury or accident

coming from the external environment. But this does not mean that there are no predisposing factors in the personality make-up of the patient. In fact there always are such factors only they are so insignificant as to escape notice.

The nature of symptoms is largely determined by the personality make-up of the individual. They are usually hysteria, whether conversion hysteria, anxiety hysteria or hysterics as have been already described. Traumatic hysteria may be discussed in detail as there are thousands of such cases who suffer from headaches, pain or depression due to minor car accidents. As has already been stressed the severity of the symptoms has nothing to do with the seriousness of the injury. In fact very serious injuries may be followed by very mild reactions and even very minor accidents with little or no injury, even the anticipation of an accident or injury, may lead to very severe symptoms. Page quotes a case from Janet. A man while riding a train in motion, foolishly got down on a step to pass from one door to the other. At that moment he became aware that the train was about to enter a tunnel and that his left side, which was projected, would be crushed against the arch of the tunnel. He fainted, but fortunately he was taken inside the train without suffering the slightest injury. Nevertheless, he developed a paralysis of the left half of the body.

In most cases of traumatic neurosis there is a latent predisposition to develop a neurosis and all that the injury or shock does is to bring it out. Repression and dissociation are present, and so is the desire for compensation, self-pity, fear of being rendered useless for work and grievance against employer. The patient seems to have a vested interest in his symptoms and therefore prognosis is poor. When the damages are paid or it is decided that no damages are due symptoms begin to disappear. As in other neuroses the patient sincerely believes in the reality of his symptoms. He is not faking or pretending to be ill but it is difficult to distinguish between the real and the fake patient.

The symptoms described here are of severe cases of traumatic neuroses. They are not the result of physical injury but of the disruption of personality. They may be seen in a person who has



been severely injured in body but they may also be observed in a person who has not at all been harmed. It is important to understand that we all have shocks in life and probably most of us have been involved in one accident or the other during the course of our lives. Why one person shakes off the experience of such accidents and another succumbs to it is not known. It must be due to personality factors already present in him.

*Treatment* : Milder cases improve with a sedative or a few drops of tincture ammonia aromatic given in a spoonful of water. Good results may also be obtained by talking out the incident with the patient. Often it may help to go through the experience or activity which has produced this shock once over again. Most often the trouble does not last long and the abreaction method to be described later is quite helpful.

#### *Psychoneuroses in physical disease*

It has long been recognized that mental and emotional factors influence physical health. We have already pointed out how certain bodily ailments follow acute attack of anxiety, depression or anger. American doctors have testified that a large percentage of patients seeking medical advice and help do not suffer from any bodily trouble but are seeking mental and emotional support in their tensions, worries, obsessions and the like. That is why modern medicine insists that in the treatment of physical disease doctors should try to understand the whole person, his entire background, mental, emotional and social. The importance of the study of psychological factors in the diagnosis and treatment of physical ailments is called the *psychosomatic approach*, and has already yielded very favourable results in curing disease. If our aim is to cure the patient rather than the disease we must study the individual as a whole taking into account emotional and mental factors.

Perhaps disorders of the heart provide a very clear example of how important is this psychosomatic approach. A large number of people who complain that they are suffering from a bad heart have practically no organic defect. The symptoms are usually the product of suggestion, misleading information and anxiety. Individuals who have lost one of their parents

due to heart trouble frequently are led to think that they too have a defective heart. This belief is strengthened by their own anxiety and fear, and in course of time prolonged anxiety and fear may actually bring about symptoms of the heart trouble. Worry and emotional factors so weigh upon them that a weak heart really does become defective.

We have already studied the effect of anxiety, worry and other strong emotions on the digestive system. Businessmen who work hard and are constantly worried about their financial transactions often complain of indigestion, heart-burn and discomfort. Some of them develop peptic ulcers because of prolonged and intense emotional strain. We have already treated at length the interaction of physical and mental factors.

Often lack of emotional outlets may produce restlessness, palpitation, sleeplessness, headache, indigestion and the like. A young idealist who refrains from sex relations but at the same time allows his imagination to stimulate his sex impulse is in for real trouble and should not be surprised if he suffers from psychosomatic disorders described here.

People who are confined to bed for a long time may develop utter lack of confidence in themselves and pose a threat to the integrity of their personality. It may also make the patient expect sympathy or may lead him to indulge in excessive self-pity. He may unconsciously desire illness and this is another threat to his personality.

## QUESTIONS

1. Distinguish between obsession and compulsion, and describe the important symptoms of obsessive-compulsive states.
2. What are the main causes of obsessive-compulsive states and what traits of personality favour them?
3. What is a phobia? What are the common types of phobias? How will you deal with phobia reactions?



4. What are the general causes of phobic reactions? How will you deal with them?
5. What is a war neurosis? What are its causes? What traits of personality favour it?
6. Give an example of traumatic neurosis? How can such a case be treated?
7. Give an example of a psychoneurotic whose trouble is due to prolonged illness. How will you deal with him?

## General Causes of Psychoneuroses

After having studied the several types of neuroses we are in a position to discuss the general causes of such behaviour and indicate the importance of several factors in bringing about psychoneuroses. As these factors interact and contribute to the development of such abnormalities of behaviour in a very subtle way and it is not always possible to pin-point what particular factor has worked most. Such discussion can mostly serve the purpose of understanding. Page has listed the difficulties of such a subject, and according to him, in the first place there are so many types and degrees of neurotic behaviour and each type has its own origin and causes that it is not easy to indicate general causes of such types of behaviour. It would be far more understandable to indicate separate causes of each type of neuroses as we have tried to do in the last two chapters. Secondly, with multiple factors working in any psychoneurosis it is difficult to assess their relative importance. Thirdly, the same symptoms may result from a variety of different causes. Fourthly, symptoms of any psychoneurosis are not peculiar to it alone.

Coleman classifies the general causes of psychoneuroses into three types, biological, psychological and social, and we may consider them under these three heads.

### *Biological factors*

The most important biological factor is heredity, and psychopathologists are not clear as to what part heredity and constitutional factors play in neuroses or in other mental disorders. Some authors attribute every type of mental disorder to heredity as other authors trace every mental ailment to environmental influences. A few studies which have been made of army people and civilian population show that neurotic patients always have neurotic parents and these disorders do run in families, but whether on this evidence we can attribute all psychoneuroses to



inherited dispositions may not be justified. But heredity is a contributory factor.

However, certain biological factors seem to be very important in the development of the neuroses. Our mental conflicts produce real physiological changes and on these changes are based some of the neurotic symptoms like anxiety, tension, palpitation, digestive disturbances and over-sensitivity to certain stimuli. In some families every small trouble is much cared for, every member of the family worries about it and it is considered a sign of more serious illness. Such fears and worries may cause further disturbance in digestion, and of course prolonged illness has at least this pleasant effect that it releases the patient from all responsibility for arduous tasks. This is an easy way to develop psychoneuroses.

Worry, emotional tension and fears have biological effects in loss of sleep, loss of appetite, headaches, fatigue and listlessness, and they lower the physical and mental resistance of the individual. Physical illness, over-work, poor diet and other biological conditions also lower the resistance of the individual and pave the way for the development of all sorts of psychoneuroses. Too often people are ready to accept that anxiety has caused physiological changes like indigestion and headaches but they cannot accept that lowered physical health and resistance makes them prone to anxiety, sensitiveness, loss of temper, irritability and exaggerated worry about one's physical condition. Fatigue is often put down to over-work, malnutrition or run-down bodily health. This may be quite true. But equally true it is that prolonged emotional conflicts also have the same effects.

Things are much more complicated when psychological symptoms are added to an already present illness. The physical illness does cause psychological symptoms, rather the latter are a reaction of the individual to his physical illness, that is the way he responds to the stress of physical disease.

But the biological factors involved in conversion hysteria are even now not clearly understood. How neurotic anxiety is translated into a paralysis of the arm or the leg, how such mental factors are converted into loss of pain or fever is still a puzzle.

*Constitutional* factors also affect a person's predisposition to certain physical and mental ailments, and include all those biological and psychological aspects of his make-up, whether inherited or acquired, which enable him to resist or fall a victim to disease. They consist of his bodily build, sex and temperament, and are influenced by nourishment, climate and physical disease.

Many attempts have been made to classify people on the basis of their constitution. One such attempt tries to trace personality to physique. People were distinguished into long, thin, short, stocky or athletic, muscular build, and an attempt was made to find personality traits peculiar to each type. No student of psychology will accept this as having any degree of accuracy. In the first place such classes are not mutually exclusive and several individuals may fall into more than one type. And some individuals may not fit into any type at all. The fact is that human beings vary so much in physique and personality patterns that it is difficult if not silly to try to fit them into a few holes.

*Endocrine glands* are relatively small in structure and their function is to secrete chemical substances known as *hormones*. These hormones are discharged into the blood stream. Though they are very small they are very powerful in their influence on the structure and function of the body. They act together, influence each other and depend on each other. If one of them is under-active or over-active it affects the working of the others. Two or three of them may have a joint work in controlling specific functions. Here a brief description of their specific function is given separately only to facilitate better understanding.

The *thyroid* situated at the base of the neck discharges the hormone *thyroxine*. If this gland is under-active and this hormone is deficient the individual becomes an imbecile and inactive, if it is over-active he becomes unstable and tense. If it works in moderation it may produce changes ranging from lethargy and mental dullness to psychomotor hyperactivity and general alertness. Under-active thyroid in children will make them ugly, feeble-minded dwarfs, they will have heavy features and stupid expression. If it is over-active children will grow into giants,



with puffed features and very sluggish in movement and understanding. Excessive discharge of its hormone quickens the speed of bodily processes, the individual loses weight, and rapid pulse, palpitation, sleeplessness and restlessness are common.

Close to the thyroid are located the *parathyroids* whose removal or destruction produces tremors, twitches, cramps and convulsions. The individual becomes very irritable, unstable, and short-tempered.

The two *adrenals* are found at the upper end of each kidney. Each gland consists of two parts, the outer part is called the *adrenal cortex* and the inner is called the *adrenal medulla*. The former secretes *cortin* which is essential to life and its deficiency leads to extreme fatigue, loss of appetite, irritability, insomnia, lethargy and darkening of the skin. Its excess stimulates the development of male sex characteristics in both sexes. Women who grow beard and develop masculine physiques suffer from an excess of cortin. If this excess takes place in early life in boys it hastens puberty. The adrenal medula secretes *adrenin* only in emergency, in stress situations, in times of great emotional excitement. In situations marked with strong fear and violent rage, muscles require greater energy for flight or attack and extra energy is supplied by adrenin. It speeds up circulation, helps quick breathing and supplies sugar from the liver. It helps greater supply of oxygen also.

The *pituitary* gland is called the master gland because it exercises control over other glands as well. It is located in the temple and secretes a hormone which is responsible for growth. Its over-activity makes young people grow into giants seven to nine feet in height. Giants are sterile and are short lived. If it becomes over-active in adult age, the organism may not grow in height but there is general thickening and expansion of the bone structure, the head and the jaw bone may become larger, the nose becomes broader and the feet thicker giving the individual the appearance of a Gorilla. Its deficiency may produce midgets. Unlike cretins midgets are of average intelligence and do not look ugly. They are well-shaped.

The pituitary gland also affects the sex glands.

*Gonads* are sex glands. The male sex glands are *testes* which produce sex cells and secrete hormones which are responsible for the development of masculine, physical and mental, traits. The two hormones known so far are *testosterone* and *androsterone*. These hormones are secreted in large quantity during puberty and produce sex characteristics like the growth of the sex organs, appearance of the hair on face and body, deepening of the voice and development of masculine body shape.

The female sex glands are *ovaries* and secrete hormones of *estrogen* and *progestins*. They are responsible for the production of ovum, menstruation and pregnancy, for sex maturity and for the development of female sex characteristics both physical and mental. In late forties they determine what is called menopause or climacteric which means a change of life for women. This period is marked by irritability, restlessness, mental depression and sleeplessness. Their cause is mainly physiological but some women begin to expect them and get them. In neurotic women these symptoms are more pronounced, and can be treated effectively by psychotherapy or injection of hormones.

The *pineal* gland is attached to one of the ventricles of the brain. Its real function is not known but it is generally held that it controls the rate of physical growth.

As has been stressed above these glands work together and are inter-dependent. If they work in harmony and balance the individual is happy and well-adjusted. But if this balance is disturbed there may be disorders of behaviour and personality. The adequate and normal supply of hormones is essential for the normal physical and psychological development of the individual. We have already seen that under-activity or over-activity of any endocrine gland may have marked effects upon psychological functions, and that anxiety, fatigues or restlessness may be due to under- or over-supply of hormones. Imbalance in the functioning of the glandular system will produce physical anomalies which lead to psychological disturbances. It is not easy for midgets, bearded ladies, giants or very fat persons to continue to be happy and well-adjusted. Too often they are exposed to ridicule, people make fun of them and they are not



able to mix with people as freely as they would have done if they had been normal.

In a general way the endocrinal glands play an important part in bodily, mental and emotional development, and if their functioning is defective, they may contribute to disorders of behaviour. It may not be that such defective functioning by itself is the cause of disorders or at the worst may be causing only a small percentage of abnormalities.

On the other hand it is argued that defective functioning of the endocrine system has nothing to do with abnormality. Hardly 5 per cent of the abnormal behaviour patients have gland trouble and the number of patients suffering from glandular deficiency or irregularity found suffering from psychoneuroses is equally small. And a large number of mental patients who have been given extracts and various preparations of hormones have shown no improvement.

### *Psychological factors*

Psychologists are not agreed about the psychological origin of psychoneuroses and we may trace some of their views on the subject. This will help a better understanding of the psychological factors involved in psychoneuroses.

Adolph Meyer laid the stress on unrealistic levels of aspirations. Many people have no realization of what they are really capable of achieving, have too high ambitions and do not accept themselves for what they really are. For mental health it is very necessary that they should know themselves in all their strong points and weak points, and to formulate their goals and objectives in life according to their capabilities. Failing to accomplish their high goals they feel frustrated, develop inferiority feelings, apprehensiveness, timidity and other defective emotional adjustments, and ultimately this leads to the development of psychoneuroses as a sort of defence reactions to protect themselves from embarrassment, distress and disgrace.

In his early days Freud stressed the fact of psychic shock and its association with sex in childhood as being important in producing psychoneuroses. Later the "Oedipus situation"

in which the child has incestuous wishes for one of the parents brings about frustration and conflict and was cited as the cause of neuroses. Still later Freud stressed the frustration of sex impulses as the major cause of neuroses, this frustration being caused by social norms and codes and their restrictive influence. Sex instinct and social experience conflict, the demands of both are urgent and powerful. Still later Freud left it to the unconscious and its contents to explain the psychoneuroses.

Adler's approach resembles that of Meyer in so far as he stresses that our life is largely competitive and in this competition for more and more fruits the individual fails to assess himself correctly, to accept himself as he is, and, therefore, develops feelings of inferiority. The neurotic is one who is afraid of entering into the field of competition and shies away. Neuroses are excuses for his failures. Adler's approach does not explain satisfactorily all the symptoms of neuroses but helps to understand some of them.

Later Fenichel traces neuroses to emotional conflicts of childhood and observed that later environmental influences revived those conflicts and produced neurotic reactions. An adult who was always rebuked and condemned in childhood may react to his environment with diffidence and develop feelings of insecurity and hostility. Such feelings may persist till he achieves some success in love or employment.

Karen Horney has particularly stressed how the child reacts in a hostile manner to the parent who rejects him and that this feeling of hostility is the basis of later neurotic reactions. Because hostility is dangerous to express openly, it is repressed. But it is possible that such hostile wishes may break through the unconscious and express themselves in outer behaviour. Such a step will meet with retaliation from the parents and bring about unpleasant results. So he learns to suffer and spends most of his time and energy in fighting his own dangerous desires and wishes. He cannot fight for his rights, has to suppress his legitimate needs and is a victim of inner conflicts. This weakens his personality and paves the way for the development of neurotic reactions. Horney puts forward three types of personality : favourable, unfavourable and indifferent and by



extending his approach to neuroses includes the factor of disturbed social relations as contributing to neurotic reactions. In his attempt to adjust himself to his social environment the individual may take one of the three approaches mentioned here. He may be afraid of joining the social drama, feel inferior and insecure, incapable of competing in the world and, therefore, may withdraw from it. This attitude of retreat is one type of reaction in which he keeps away from the give-and-take of social participation. If he does try to meet people and share their collective activity and experience he feels very anxious and fearful. As things are it is hard to avoid social participation and, therefore, the inner conflicts play havoc with him. If on the other hand he continues to keep away the feelings of apprehension, insecurity and inferiority become deeper and lead to anxiety, dissatisfaction and self-devaluation. Thus his adjustments instead of solving his problems make them still more difficult and lead to neurotic behaviour.

In dealing with different kinds of neuroses we have again and again stressed that the patient persists in his reactions, he clings to his symptoms for they protect him from anxiety and conflict though in a superficial manner. This basic fact must be kept in view in understanding the psychology of psychoneurotics. As symptoms grow in intensity, his adjustments are worse, and the worse the adjustments the more violent symptoms become. This vicious circle is the keynote of neuroses.

Study of case histories has revealed that it is the conflict and faulty adjustments of childhood which predispose a person toward neurotic behaviour. Feelings of insecurity and inferiority engendered in childhood by over-strict discipline, poverty or continued failure pave the way for the development of neurotic symptoms later on maturity.

Generally there are three factors involved : (1) when the individual feels incompetent, inadequate and incapable of reaching the goals and ambitions of his life or has failed to do so and feels inferior and low, (2) when dangerous desires of sex or hostility seem to break through his defences of symptoms, or (3) when the individual thinks and feels that his situation is intolerable and there is no way out of it. Life's tragedies, failures,



disappointments and strong feelings of hatred and love all contribute to such feelings and we all suffer from them. In mild or strong degrees we all have neurotic trends and resort to protective devices in the form of symptoms to escape such situations.

The phenomenon of anxiety is central to psychoneuroses. In normal persons it serves the biological purpose of making us take measures to avoid it, but among neurotics this purpose is not served. The emotion of anxiety is universal and is associated with restlessness and increase in muscular tone, and the heart and the vascular system prepare the individual for action—the pupils dilate, the hands tremble, and palms of the hand and soles of the feet become damp. Victims of anxiety feel the need to move about, to act, to decide, and thus to end whatever dilemma they find themselves in, and the anxiety tends to increase till they are forced to take a decision, whereupon, even if the decision is wrong, the anxiety subsides. Normal anxiety is removed when the mind is made up and measures have been taken to deal with the source of anxiety. Except when there is a national upheaval or disaster and anxiety takes the form of panic, the emotion of anxiety is so unpleasant that every one is compelled to take suitable steps to remove its source. Anxiety is useful in so far as it helps us to adapt ourselves to the world, to avoid danger and trouble if we can, and deal with it if we cannot. But the neurotic reacts very badly and inadequately to the stress situation. He may experience more anxiety than most or may experience more anxiety because he cannot identify the threats. Having developed much intenser anxiety, he may fail to deal with his problem and thus add to his anxiety or he may get rid of his anxiety by means which leave the source of anxiety untouched and thus may increase his troubles in the long run. The several types of psychoneuroses dealt with in the last two chapters indicate how such troubles are built up and intensified.

The personality make-up of some individuals is such that it inclines them to certain types of neuroses. Anxiety-prone people experience mild apprehension even in the face of minor troubles. We can say that they have an anxiety-ridden personality. They are tense and jumpy, and under unusual strain, they may lose their



efficiency. Even in decision-taking they are quick but do so on whatever evidence is available. In a physical emergency it may be helpful but fails when subtle decisions have to be taken in complicated situations. Such people usually develop, what have been described as *anxiety states* in a previous chapter. The symptoms of such a neurosis have already been discussed.

The patient with prolonged anxiety is uncomfortable, cannot sleep, may be irritable and jumpy and tire easily because of muscular tension. He may call in alternative but neurotic mechanisms to deal with anxiety. One well-known method which has already been described in detail and which is adopted to deal with discomfort of anxiety is to develop *hysterical conversion symptoms*. Some people are able to fall ill in an apparently physical way when anxiety is too much for them, and this illness excuses them from the responsibility of tackling their problems. One well-known symptom is amnesia in which the patient forgets all about himself, his identity and past. It is difficult to distinguish between hysteria and malingering, and many such patients are escaping or trying to escape from the consequences of a crime or misdemeanour. Hysterical symptoms are found among people who are somewhat primitive.

Hysteria conversion symptoms are likely to be produced by patients known as hysterical personality, a provocative and emotionally shallow personality, often inclined to be theatrical and showy.

Persons suffering from obsessive-compulsive reactions are inclined to be neat and tidy, parsimonious though quite hospitable, conscientiousness to a greater extent than is necessary or comfortable, attached to a routine and uneasy about violating rules even to a minor extent. He is a good person to have as a subordinate, may not be convenient as a colleague but is a critical superior. This kind of person is rendered uneasy by any disturbance of routine and by pangs of conscience at the slightest departure from accepted rules.

Phobic states occur when anxiety is centred on an objective neutral situation, common one which has a special meaning for the patient or which has a tendency to cause anxiety and fear. Such patients are usually women and they may become phobic

about travel, bridges, dogs, heights or closed rooms. Such phobic reactions divert attention from the real source of anxiety and the effects of phobia provide a support to this emotion.

Psychological causes of psychoneuroses have been given in detail and a good many points have been repeated from the earlier chapters. But it is hoped that this repetition will help a better understanding of the subject. It must, however, be borne in mind that causes of neuroses are multiple, including physical, constitutional and psychological and any systematic treatment must have a wide application and take into account all the possible factors operating in the life of the patient.

Readers are also referred to various theories put forward by psychoanalysts for explaining the origin of psychoneuroses. These theories do not contradict each other, rather they contribute to the whole picture.

### *Social and cultural factors*

The psychological ailments of man are not a product of modern civilization as is very commonly supposed. Mental defectives, insane people, hysteric patients, some acute neurotics and the like have been referred to in history and literature of the past in all countries though treatment of such patients has varied from culture to culture and from one social structure to another. From what descriptions of their symptoms are available it is evident that they were very much similar to what we find today. Nor are these ailments peculiar to any particular class or group of society. Psychoneuroses and psychoses are found as frequently among educated classes as they are found among the uneducated, the rich are afflicted as much as the poor. Professors and prostitutes, lawyers and criminals, businessmen and labourers, politicians and delinquents, men and women, all have their share of neurotics. However their incidence varies very widely for different groups and sections of society. Page says "Anthropological studies have shown that even the most primitive people are afflicted with mental deficiency, psychoses, psychoneuroses and criminality".

As has already been pointed out hysteria is more common among primitive peoples and among patients from lower economic



and educational status. Anxiety reactions and obsessive-compulsive reactions are found among richer and better educated classes. During the war hysteria was more common among private soldiers than among officers while anxiety was more common among officers. Generally speaking psychoneuroses are more common among educated and cultured people than rural or backward classes. Among people whose social life is largely controlled by social norms and codes psychoneuroses are less common. Most of the conflicts of life are solved according to tribal traditions and the range of tension is reduced. Similarly among races where the role of custom and tradition is very powerful or the law of destiny, God's will or Karma is widely accepted the range of tensions, anxiety and conflicts is smaller, disasters, failures or disappointments are accepted as a part of our destiny, and there the matter ends. In those social organizations in which the idea of individual responsibility is strong, where initiative and industry are considered basic to success and happiness in life, and where people are highly educated, rational and intelligent neurotic reactions are more common. In modern civilized living where competition is found in abundance and where social relations are more complex and complicated, tensions and anxieties are greater in number and intensity, and psychoneuroses are more common.

The pace of modern living is greater, everybody is engaged in getting ahead of others and in this fast race everybody does not come out victorious. Life's defeats, failures and disappointments are varied and numerous—all the more reason for greater incidence of neuroses.

A study of the life history of criminals, delinquents and abnormal people reveals that most of them had one or more of the following influences in their childhood :

1. Financial stringency in the home, poverty, financial losses, failure in business of parents, unemployment.
2. Broken homes, frequent clashes between parents, separation of parents.
3. Neglect on the part of parents, loss of affection, too many brothers and sisters, unwanted children.

4. Disappointment in love affairs, inability to marry for reasons over which he or she has no control.
5. Terrifying experiences like war, earthquakes, fires, communal riots.
6. Loss or death of dear and near ones.
7. Loss of position, scandal in the family.

In the development of psychoneuroses such unfortunate episodes of life may serve to produce, precipitate or aggravate neurotic reactions. As these episodes are almost universal and are found in the life of everybody, they cannot be accepted as the sole cause of psychoneuroses. Almost everyone at one moment or the other of his life has had to face the challenge of stress and strain situations which produce deep anxiety, and such situations may be similar to those felt by psychological deviants. But how is it, one may ask, that some people develop neurotic reactions and some do not? On the other hand we cannot ignore such factors as merely incidental, having little or no effect on the development of neurotic reactions. The only alternative left is to hold that such life situations precipitate or aggravate neurotic trends already present in the individual. When they are experienced by people with strong stable minds who take the rough with the smooth bravely and realistically they do not have serious consequences but when they are experienced by people who are predisposed to psychological disturbances because of their heredity or past history they lead to the development of psychoneurotic reactions.

Perhaps the disasters which upset the life of the people on a national scale show very clearly the importance of distressing emotional experiences. The war ravaged populations of Europe have not been systematically studied from this point of view but a few accounts that are available show that it is the armed forces which suffered most from neuroses. The economic depression, lack of material resources, loss of relatives, unemployment and the like had their usual effects but there was no evidence of any special increase in neurotic cases. In our own country the large scale murders, looting and other disasters which overtook the people migrating to and from India told badly on the mental



stability and balance of thousands of people. Though no systematic study was made the general impression is that people from West Pakistan stood the ordeals and deprivations of partition bravely and with a stout heart. There was no marked increase in the incidence of neurotic reactions.

A question very often raised is : Are there certain races more prone to psychoneurotic reactions? Are there any nationalities or sections of them which are more neurotic than others? No systematic studies have been made so far and what prejudices and opinions are available are just impressions of people generalized on the basis of isolated experiences. Because countries which have provided more extensive facilities for the treatment of psychological disorders also offer more accurate records of psychological ailments people naively assume that those countries are more afflicted by such ailments. The fact that African tribes have no facilities or records does not prove that there are no psychoneurotic patients. This truth is too obvious to be laboured. Again some Indians are inclined to think that countries in which drinking habits are widely prevalent must be having larger number of neurotics, but this should be noted that alcohol is just one of the several causes and by no means a very potent cause of psychological troubles.

How far cultural factors contribute to psychopathology is a point to be studied. Various cultures favour the development of individuals in different directions. Apparently the majority of the individuals in all groups are malleable enough to adapt themselves to these requirements, but others, in part on the basis of genetic constitution are not. This may then result in abnormal behaviour which does not conform to cultural norms. Hindu society and culture has enjoined a certain type of behaviour which is expected of all Hindus. Respect for parents, arranged marriages, use of sacred thread and other religious symbols, in certain castes, abstention from certain foods, carrying out daily routine of religious rites and the like. Most Hindus conform to them, and some do not conform to them but non-conformity is ignored, but in some sections of Hindu society such non-conformity is not condoned, and then there is a conflict at the social level as also in the mind of the non-conformist resulting in anxiety and



abnormal behaviour. Some young people marrying an English wife are with minor adjustments welcomed back to the family and the caste, but others are thrown out with psychological consequences to both parties. There are several primitive tribes in which personal ambition is looked down upon and a person who gives evidence of this trait is so severely punished that he may lose his life. Such unnatural curbs and taboos do lead to psycho-neurotic behaviour. Wherever patterns of culture come into conflict with personal likes and dislikes, ambitions and goals, the individual cannot function with comfort and will break down psychologically for he depends on society for self-approval.

Again no culture is entirely homogeneous. There are sub-cultures within a culture ; geographic conditions, economic factors, caste, status, occupation and the like produce differences of culture among groups of the same society. This is specially true of Indian culture which is a composite of several sub-cultures. And each sub-culture has its characteristic conflicts and is exposed to prejudices of other sub-cultures. A Jat, a Brahmin, a Bania or a Rajput are not merely caste names but also stereotypes denoting certain characters which are nothing more than inter-caste prejudices. These create problems and conflicts, precipitating neurotic reactions.

Then there are certain social institutions which add to our insecurities, as payment of high taxes, soaring prices, unemployment, and the like and they add to our anxiety. Even relatively simple groups like the village community has its sources of anxiety like the failure of rain, disease, famine which are attributed to the wrath of God for their own misdeeds of the previous life or of the present. Such unconscious fears may lead to adjustments which are not quite healthy. It may lead to vague self-condemnation and guilt, despair and intolerable situations, and such stresses produce neurotic trends.

Our society under the impact of technology is becoming more and more mobile. People move from place to place, they rise and fall in economic status, and their social status is also subject to change. This mobility stimulates unattainable goals, frustrations, feelings of loneliness and isolation. It also offers hope of getting out of intolerable situations and enables the individual to find a



place for himself in the vast world. These are consolations, compensation and substitute gratifications.

The effect of different forms of government on the mental health of the individual have yet to be methodically studied but by and large the authoritarian political constitutions produce more conflicts as is evidenced from the defections taking place every now and then.

But the most important factor is the individual's personality and his experience in the social order and culture in which he is born and bred. Favourable experiences for one individual may be unfavourable for another.

### QUESTIONS

1. Discuss some of the most outstanding factors in the origin and development of psychoneuroses.
2. Discuss the biological factors favouring neurotic reactions. How far endocrine glands lead to psychopathology?
3. What psychological factors are responsible for psychoneurotic symptoms? Illustrate your answer.
4. Discuss how anxiety is basic to all psychoneuroses.
5. What important influences and experiences in early childhood make for psychoneurotic trends?
6. Indicate some of the important social and cultural trends of modern times and show how they lead to mental disturbances.

## Psychological Treatment or Psychotherapy

Before attempting the treatment of mental disorders it is very necessary that we should know all about the individual, his symptoms, his past history, the nature of his personality and the nature of the physical, economic and social environment in which he lives and moves. In the first interview with the patient the therapist only tries to elicit information from him. He will ask questions and then let the individual talk. It is much more helpful to prepare beforehand a list of questions about various things he wants to know and then repeat those questions with every patient so that some standard is laid down for all. But the therapist must guard against making the whole process too mechanical and dull. It is better to lay down the points on which information is to be sought and then frame questions there and then to suit the nature, standard of education and temperament of the individual. Since we are dealing with personalities rich in variety of responses it is very important that each case be dealt with in a way suited to the needs of the patient. If a person is not inclined to talk freely the therapist may have to win his confidence and then encourage him to talk and if he is free and frank he may have to be given suggestions to talk only relevant details and not waste time in giving details which are not needed. A rambling talker will have to be guided now and then in the course of the interview. Such detailed personal information about the past and present of the individual is called *case history* and will provide information about the following areas of his life and work :

1. Name, age, marriage position and other details which will help to identify him.
2. Nature of the present symptoms and difficulties, when and how they began and developed.
3. Physical health : Are there any physical symptoms? How strong physically the patient is? How active and agile he is in his daily life? Has he received any injury in the past? What are the common ailments



he has suffered? Has he had any serious illness? What was its nature, duration and treatment? Is he addicted to anything, alcohol, smoking or drugs? For how long has he used them? How did he start using them?

4. Family history : Physical health, habits, mental health and personality make-up of parents and other members. Is there any unfavourable hereditary influence?
5. History of any previous mental disturbances.
6. How well does he mix among his colleagues and companions in work and recreation? Has he many or few friends? How well is he adjusted toward them? Is he popular or otherwise? Any peculiarity about his social adjustments?
7. His general personality make-up, his habits, emotional attitudes, attitude toward himself and others. Does he feel happy, safe and secure? How intelligent is he? What are his major interests and hobbies, recreations and pastimes? What type of temperament has he? Is there any eccentricity in his behaviour?
8. Background of early childhood, atmosphere in the home, the nature of treatment he received from his parents, brothers and sisters and others, important childhood experiences, his relations with his playmates, the nature of neighbours and relatives, temperamental and emotional attitudes of parents and other members of the family.
9. Psychosexual development, early sex experiences, his and his parents' attitude toward sex, his adjustments in marriage.
10. His experiences in the school, the level of his education, the quality of his work in the school, the treatment he received from his teachers and classmates, his general attitude toward the school, its programmes and objectives.
11. His history in his occupation and profession : Is he deeply interested in his work, how does he like his

job, his colleagues and his superiors? Have there been periods of unemployment? How long has he held any job? What is his capacity for work? Is he conscious of the social value and importance of his occupation?

12. What are his life goals? Is he doing his work only to earn money? What does he expect from his children? Is he satisfied and happy with what he is, with what he has and with what he hopes to accomplish in his present position?

Such a comprehensive case-history when completed will be of great use to any clinician who attempts to treat a case of mental disorder.

### *Psychological tests*

There are great many tests designed to measure various aspects of the personality organization of the patient. In considering such tests we may group them into two classes : non-projective and projective, and these are described here in detail.

1. Non-projective tests include tests of intelligence, interests and aptitudes, questionnaires, inventories and rating scales. For measuring intelligence Stanford Revision of the Binet Simon scale and Wechsler Bellevue tests for adults are most frequently used. Psychologists have been identifying and classifying value patterns in an effort to determine their effect on vocational choice and on success in school and on the job. One of the earliest of these efforts was the Allport Vernon Study of values which measures the degree to which individuals prefer aesthetic, religious, economic, political, social or theoretical values. Kuder Preference Record or the Strong Vocational Interest Blank for men and for women are quite popular. There are several research studies which seek to verify the existence of different patterns of interest characterising people in different professions.

The most elementary variety of personality questionnaires is a self-report type of instrument that asks the subject to respond to questions such as the following :



Yes No Do you find that other people are prone to give you more advice than you need?

Yes No Do you enjoy driving faster than the law allows?

Yes No Do you find it difficult to "get going" in the morning?

Yes No Do you often find that you are tired for no accountable reason?

Yes No Do you often find that other people do not like you?

Or the simpler type :

1. How often do you get angry when things go wrong with you?
2. Are you fearful about life?
3. Are you easily discouraged?
4. Do you try to escape from unpleasant responsibilities you should face?

By classifying the responses to such questions it is possible to find clues to the kinds of problems the subject is facing and the ways in which he is coping with them.

Responses to the California Test of Personality can, for example, be scored on the following scales :

*Personal adjustment*

Self-reliance  
Sense of personal worth  
Sense of personal freedom  
Feeling of belonging  
Withdrawing tendencies  
Nervous symptoms

*Social adjustment*

Attitude to social standards  
Social skills  
Anti-social tendencies  
Family relations  
Occupational relations  
Community relations

This test is scored by comparing the number of "good adjustment" responses made by an individual with the test normals—a scale based on the responses of the people on which the test was

standardized. It is thus possible to say if the individual's adjustments are better or poorer than that of the norm group. One serious drawback of these questionnaires is that it is always possible for the individual to know what responses are favourable and to modify his responses accordingly.

One of the major clinical non-projective tests is the Minnesota Multiple Personality Inventory. The Minnesota Multiple Personality Inventory consists of 550 test items covering topics from physical condition to moral and social attitudes. The subject checks those which apply to him. Some sample items are given below :

I sometimes keep on at a thing until others lose their patience with me.

Bad words, often terrible words, come into my mind and I cannot get rid of them.

I often feel as if things were not real.

At times I think I am no good at all.

I do not tire quickly.

By comparing the answers of normal people with groups having neurotic disturbances, keys have been constructed to measure hypochondria, depression, hysteria and other mental disorders. There is also a masculinity-femininity scale, consisting of items on which the responses of men and women differ. Several studies have shown that the questionnaire is of great help in the diagnosis of disturbances of personality.

2. Projective tests include *Rorschach inkblot tests* and the *Thematic Apperception Tests*. They are called *projective* because in them the subject tends to project his own characteristics into a response to a situation that is vague and undefined. It is based on the assumption that the individual reveals his own characteristics by what he sees in his environment. The situation is very indefinite, it frees the individual from any social conventions and reality, and he is able to give free expression to himself. He has no idea what is a good answer and, therefore, his responses are uninhibited. He is not able to distort his answers.

The Rorschach Inkblot test is the most widely used projective



technique. In its present form it was first devised by Hermann Rorschach, a Swiss psychiatrist. The material consists of ten ink-blot patterns, five of them are black, two are black and red, and three are entirely in colours. The cards are presented to the subject one at a time, the examiner saying only, "What might this be?" The examiner writes the subject's responses in full. After the ten cards are completed, the examiner goes through them a second time to make a record of where the subject saw each thing that he mentioned. Each response is scored with respect to three features : *Location*—whether the response was based on the whole blot or on a detail ; *Determining quality*—whether the response was determined by the form of the blot, its colour, shading or movement, and *Content*—what is seen, that is, human figures, animals, objects, maps, landscapes and the like. The scoring is extremely complex, and only a person who is well-trained in giving and interpreting the test is able to handle it.

The Thematic Apperception Test uses twenty pictures, each to be shown to the person taking the test in order that he may tell a story about the picture and tell what he thinks the thoughts and feelings of the people in the picture might be. What you would have to say about the picture, it is believed, will tell something about your personality. What you would make the hero or heroine of the picture say or think will probably reflect what you yourself would say or think in similar situations.

### *Physical examination*

Before psychological treatment is undertaken a thorough medical check-up is very necessary even if it is quite obvious that the patient is suffering from some form of psychoneurosis. As has already been stressed often physical disorders give rise to psychological troubles. Besides many patients of psychoneurosis firmly believe that they are suffering from some form of physical disease and that if they need any treatment it is for their physical illness. So it is always to the advantage of psychotherapy that one should make sure about any possible physical handicap, defect or illness. It will at least remove the strong belief of the patient that he is physically ill and he will not refuse to be treated on a psychological basis.

Too many clinicians are inclined to humour the patient and agree that he is really suffering from vague physical illness. This is very injurious to the patient. He should be frankly and firmly told that there is no organic defect and that he is not having any bodily disease. Such an approach facilitates the effectiveness of the psychological treatment and wins the co-operation of the patient which is extremely essential for the success of the treatment.

### *The nature of psychotherapy*

Psychotherapy may be defined as the treatment of personality disorders and maladjustments by psychological techniques. As has already been stressed psychological approach to the understanding, diagnosis and treatment of psychoneuroses is the most effective. Personality maladjustments and disorders are psychogenic, their source and origin is psychological, and their treatment and cure must be through psychological procedures, techniques and methods.

What should be the aims of psychotherapy? What will be the nature of techniques and procedures? These will depend on the nature of each case, the degree of intensity of the symptoms and the strengths and weaknesses of the patient as also on the facilities of psychological treatment available at any one place.

The various techniques and procedures of psychological treatment are not anything quite new but have developed from the past practices and procedures. Nor are they confined to hospitals. In a number of cases psychoneurotics are treated outside regular hospitals by psychiatrists or clinical psychologists in private practice. In India such clinics are yet very few and whatever there are, are confined to large towns like Bombay, Calcutta and Delhi.

We shall describe here some of the major psychotherapeutic aids and techniques.

### *Aims of psychotherapy*

Patients seek treatment because they have distressing symptoms which make them ineffective and inefficient, which vitiate



their social adjustments and make them and others around them unhappy, and which unnecessarily tie up vast amount of energy which could have been used with advantage for the good of the individual and the society. The aim of psychotherapy is to promote personality growth towards greater maturity, efficiency and self-expression. It should give the therapist and the patient greater insight into the nature of symptoms and the individual, help to resolve his disabling conflicts, enable the patient to accept himself as he is and strive to do better and to apply better and more effective methods of dealing with his problems, and should help to strengthen his personality so that he feels more adequate and competent to solve his difficulties and problems, and thus feels more safe and secure in his environment. Psychotherapy is to help the patient to regain self-confidence so that his problems, difficulties and issues do not leave him incapable and impotent. But these aims are by no means easy of achievement. Often the patient has acquired a very distorted view of the environment and himself. These relations and attitudes toward himself and the people around him may have been very gradually built up and may become hardened through being constantly reinforced by similar experiences. Or he may have occupational maladjustments, marriage difficulties or difficulties of social adjustment to his near friends and relations and these maladjustments are not easy to cure even with the best type of psychotherapy. Popular notion is that just as medical treatment begins to take effect immediately after medicine is administered so mental disorders will readily respond to psychotherapy, and it should be a matter of few hours for the psychotherapist to do the trick. All this is simply not possible. Psychological treatment is long and arduous, it may not succeed and definitely involves a re-orientation of personality toward adequacy and competence. Firmly ingrained traits of personality, emotional attitudes of immature character, habits of thinking and doing long established, his general attitude to life and his beliefs and deep-seated prejudices may have to be changed and modified. This is a long and patient task, and the person himself has to be persuaded not only to co-operate but to shoulder himself the entire responsibility of his own re-education. No one can change the personality for him, he has to do it himself. Most patients of psychoneuroses realize this but are



not able to help themselves. That is why they seek the help of psychotherapy.

The therapist has one great advantage. He is in a position to establish favourable emotional relations with the patient. When some rapport is established between them, when the patient feels confident that the therapist can help him, when he opens his mind to him and freely shares his innermost secrets with him, the therapist is in a better position to influence the personality and attitudes of the patient. For this the personality and attitudes of the therapist himself are very important. He should have a genuine interest in his work and patients, he should have imagination to put himself in the position of the patient and fully realize his difficulties and feelings. He should be inspired by ideals of service. He should have deep insight into human nature so that he not only understands the weaknesses and foibles of fellow-beings but is tolerant and sympathetic toward them. Only when he takes a very generous view of people can he do them lasting good by helping to regain courage and confidence to solve problems and face difficulties by their own efforts and thus acquire good mental health. When the therapist has regained the full confidence of the patient the latter will know that his worst faults, his most serious weaknesses and/or defects will not be laughed at, ridiculed, condemned or punished. Sympathy and encouragement on the part of the therapist is the keynote of all psychological treatment and those who are incapable of it should better keep away from psychotherapy.

Let us now describe some of the important aspects of psychotherapeutic procedure.

Psychotherapy may be *long-term* or *goal-limited*. One may attempt a major reorientation of personality which may involve treatment for four or five hours for five days in a week extended over a period of several years. Such a long term treatment, however desirable, can be used only by a small number of people who can afford the time and expense. Therefore, several short-term goal-limited forms of treatment are made use of in hospitals and private homes to make psychotherapy available to as large a number of people as possible. These keep in view the nature of the trouble and try to solve it. Naturally they are confined



to particular conflicts and maladjustments. These are very suitable for people who have less time and money to spare for their mental troubles.

Psychotherapy may be *surface* or *deep*. Surface treatment does not make any attempt to go deep into the emotional conflicts of the patient. On the contrary he is assured that there is not much trouble with him. Insulin or electric-shock treatment may be given or he may be advised or exhorted to follow a particular course of treatment. There are times when surface treatment is all that the patient needs. In such cases he has been a victim of extreme stress but his adjustments are satisfactory. But in depth psychotherapy deep-seated conflicts have to be uncovered and long range personality adjustments have to be aimed at.

Surface treatment is confined to relieving the acute symptoms of any psychoneurotic disturbance of relatively recent origin, or in isolating such disturbances of personality as complicates organic defects. In latter cases the organic condition must be set right first and then psychological disturbance be attended to.

*Directive* or *non-directive* therapy is considered when one has to decide as to how much responsibility may be placed on the patient and the clinician. In "directive" therapy the therapist takes the active role in the therapy situation. The initiative of uncovering the hidden inner wishes and conflicts is taken by him, interpreting them to the patient and guiding him to take effective measures toward adequate personality adjustments. In non-directive therapy he is less active and the major share of the responsibility of treatment rests with the patient. He merely creates such an atmosphere that the patient freely talks about his troubles without fear of ridicule, condemnation or punishment. He does not try to probe into his troubles but only helps the patient to understand and clarify the feelings and attitudes as they are revealed in the course of the treatment.

There is no opposition between directive and non-directive therapy, it is only a matter of relative emphasis. Few cases of psychotherapy are exclusively directive or non-directive. The approach is usually dictated by the needs of the patient. People with mild symptoms and with adequate adjustments need non-

directive psychotherapy but for those with deep mental disturbances directive psychotherapy is required.

Some authors speak of analytic and non-analytic, interview or non-interview, hospital or non-hospital therapies but these are just distinguishable aspects which need not be discussed in detail as the names themselves are obvious.

Let us now describe some of the major psychotherapeutic techniques or procedures.

*Advice :* From ancient times people in difficulties have always gone to wise men or specialists for information and advice about their troubles. In illness we go to a medical man, in social clashes we go to a lawyer. There are experts in business, income-tax or investment and we seek their advice. Then there are journalists and radio experts who are always giving advice about anything and everything. Some people, particularly old men and women, are always giving advice on intricate or plain problems. But there are two things to be borne in mind : some people seek advice but do not follow it or follow it only in part, and some people resent advice, being told what to do. Nor is taking too much advice always good for mental health, for it encourages dependence and discourages the habit of deciding independently on one's own judgment.

However, counsellors do give advice on specific problems, but it would be better to refrain from offering direct advice in any situation. It is much more useful to help the patient to discover the solution to their difficulties and problems. Some patients may be very eager to ask for advice but when given may resent it. Or if the advice does not work they blame the therapist for it. However, some patients accept advice thankfully and follow it very carefully. Still others follow the directions of the therapist rigidly and even look to him for approval. Perhaps the best course for the therapist is to give advice in such a manner as to appear that he is merely suggesting the best course under a particular type of situation and leave it to the patient to accept it or reject it, so that even if the patient accepts the advice he believes that he is acting on his own.

Or the advice may be given in very general terms so that



the patient may adapt it or modify it to suit his needs. Many clever counsellors do not give any advice but simply mention how some other people got over the trouble and advice is thus given through the force of example.

*Suggestion :* Suggestion too is an old and frequently used method of treating psychoneurotic patients. This method is frequently employed by medical practitioners who may prescribe harmless drugs and injections and along with them make suggestions. Often unqualified doctors succeed because it is not the medicine that the patient needs but the suggestions which are made alongside. Religious healing is also based on prestige suggestion and faith.

That suggestion is a useful form of treatment in mental disturbances will be borne out by a large number of stories found in every land and language as to how the power of suggestion has affected people. Medical men will bear testimony to the claim that even in the treatment of physical ailments suggestion does play an important part. Indirect suggestions are conveyed by all doctors and therapists. Some years back Coue made popular what is known as auto-suggestion or suggestion given to oneself. If you say over and over again "Day by day in every way I am getting better" you will feel better, and the patient should repeat this formula to himself a number of times every day.

How powerful is the effect of suggestion is revealed when we consider the far-reaching achievements of propaganda and advertisement. Not only psychoneurotics but also normal people would act on any suggestion if it is repeated strongly enough by a person whom they hold in esteem. Even if suggestion helps to relieve neurotic symptoms it fails to reach the underlying cause of such mental disturbance and, therefore, will not bring a permanent cure unless the cause has already been removed and only the symptoms remain.

Often patients are given harmless medicines, baths, massage or physical treatment just to satisfy the patient and indirectly suggest it to him that he is being relieved. But they also indirectly make him believe that he really was suffering from some bodily trouble. It would have been more effective to have made him

understand his trouble, how it was mostly mental and emotional and how he himself has taken a hand in his treatment.

*Exhortation :* Too many parents, teachers and doctors are in the habit of exhorting patients to pull themselves together, to have courage and exercise will-power or think of other things. Such exhortations to be effective must be made with sympathy and understanding. Usually the patient finds such advice useless as it does not enlighten him how he should help himself and is expressed in very vague language. Secondly, such an advice ignores the real cause of the trouble and makes no attempt either to find it out or to treat it.

*Explanation :* When a patient goes to a doctor he expects to be carefully examined and then explained in detail as to what is the cause of his trouble. Patients of psychoneuroses should expect the same, but a psychotherapist does not have the same instruments as a medical man to check up and find out the cause of trouble. In diagnosing and interpreting neurotic symptoms he has to rely on the data supplied by the patient himself. The patient's behaviour can be observed from outside but his mental condition can be known only to himself. So the therapist must analyse and interpret what reports the patient himself provides. Now such reports cannot be very reliable for the patient may have forgotten or expressed some of his emotional experiences. He may not like to tell the truth or may slant his report in any direction favourable to himself. Again what he thinks to be important the therapist may not consider very important. The best thing to do is to let the patient speak out, identify his symptoms and find an explanation of his trouble himself even though the help and guidance of the therapist is made available to him. Even what explanation the therapist offers should be expressed in an indirect way so that the patient feels that he himself is finding out the cause and origin of his trouble. At no point should the therapist enter into any argument with the patient about his symptoms. His ultimate aim is to build courage and self-confidence in the patient and that can be done only if the patient is allowed to feel that he is solving his difficulties himself.

*Persuasion :* This is another procedure which has been commended. After listening to the patient's troubles and obtaining his



story of the ailment the therapist should try to persuade him that he is sure to get well, that every trouble has a remedy and that he himself can achieve his recovery. But this is too simple a thing to cut any ice for causes of neurotic trouble lie deep and they must be uncovered before any improvement can be effected.

### *Hypnosis*

Hypnotism is a mental state of trance induced by suggestion in a co-operative subject. In such a state the patient is highly suggestible. The use of hypnosis in curing mental disturbances and ailments was known even to our ancient ancestors, but its systematic use in psychotherapy was first made by Mesmer whom we have already mentioned in our historical account. The role of hypnosis in psychotherapy became very popular in the times of Liebeault and Bernheim who used it in dealing with the symptoms of conversion hysteria even though they did not understand its underlying cause. There arose a controversy between Bernheim and Charcot which continued for long, the former defining hypnosis in psychological terms as a condition of increased suggestibility and the latter defining it as an artificially induced neurosis or nervous or physiological condition. But there was an element of truth in what Charcot said. Today hypnosis is primarily used in the treatment of hysterical symptoms, and also hysterical symptoms like deafness, blindness, paralysis, amnesia and others can be artificially induced by hypnosis. We may, therefore, study hypnosis in detail as an important therapeutic procedure.

Suggestion and hypnosis are normal and universal phenomena. Many characteristics of the hypnotic state may be seen in normal waking state also. Usually the technique of hypnosis employs some combination of relaxation, visual concentration and verbal suggestions. Often relaxation is artificially produced by giving a sedative, but ordinarily the subject is seated in an easy comfortable chair and asked to relax. When he is so comfortably placed, the hypnotist suggests it to him that he is sleeping. This may be done in many ways. Then he may be told to look at the hypnotist alone and not to think of anything else. "You are already feeling sleepy, your eyes are feeling heavy, relax and go to sleep", these words are repeated again and again and in a manner as to attract



the full attention of the patient and make as powerful a suggestion as possible. When the trance state is induced the hypnotist may test him. "You are so fast asleep that you cannot open your eyes. Now try to open them and you will see you cannot open them because you are so fast asleep. You will not be able to open your eyes". If the subject is unable to open his eyes the hypnotist may be confident that the trance has been induced. He may test him differently. He may tell the patient that his left hand has lost all sensations so that he no longer feels pain. When the hand is later pricked with a needle and the patient does not show any feeling of pain he has been hypnotized. Now if he is asked to lift his hand he will make an effort as the muscles will show but he will be unable to do so. This lack of sensitivity or paralysis is removed when the hypnotist suggests that he can now move his hand. He may be asked to sing and he will do that. These tests will prove that he has been completely hypnotized and he will do anything at the suggestion of the hypnotizer. To terminate the trance it may be suggested to him that he will get up completely refreshed after counting ten and so he does. A subject who has been hypnotized once will be hypnotized a second time without much trouble and effort.

Thus there are four steps in the induction of hypnosis : (1) the fear of hypnosis in the mind of the subjects should be completely removed and his whole-hearted co-operation should be ensured, (2) the subject should be seated in a very comfortable position and made to relax completely, (3) the subject's attention should be focussed and concentrated, for example, by having his eyes fixed on the gaze of the hypnotizer or on some bright light, and (4) directing the activities of the subject by powerful reinforced suggestions. These suggestions are repeated again and again.

Not all persons can be hypnotized and those who are may have varying degrees of hypnotic trance. Some are so deeply hypnotized that they can be placed like a log of wood on two chairs.

Some very interesting things have been found and done in hypnotic behaviour. Some buried memories of shocking experiences of early childhood can be recalled. In the Second World War hypnosis was used on patients who had amnesia and they were made to live and recall battle experiences. In doing so they would



discharge their emotional tensions associated with such experiences and thus recover from their shock.

The subject who is in a deep trance will spontaneously develop amnesia for everything that happened during the period of trance even if it lasted an hour. He may have carried out many actions on the suggestion of the hypnotizer but on waking up from the trance he has no memory of it. If the trance is not deep he may have some hazy recollection.

In the deep trance he will be deaf to all sounds other than the voice of the hypnotizer. At the suggestion of the hypnotizer he may develop insensitivity to pain or sights. He may limp, become rigid and have paralysis of any limb. He may also feel in the trance that what he could not do in the waking state he can do now.

He may be told that he is now six-year old and he may feel like that, act like a child and think very much as he did when he was a child. This is regressing back to early age and its great advantage is found in the study of phobias and the analysis of such symptoms as had their origin in the shocking experiences of early childhood.

A very special feature of hypnosis is that the subject carries out even after the trance is over suggestions which were made during the trance. This is called *post-hypnotic suggestion*. Thus waking up from the trance the subject is told to write a letter to a friend at eight in the evening, and the subject does set about writing that letter.

Some hypnotists claim that all the symptoms of hypnosis can be produced without inducing the patient to sleep.

### *Hypnotic therapy*

Before hypnotizing a person for psychotherapeutic treatment it is useful to have a detailed interview with him. The effect of hypnosis varies with individuals. Some go into deep trance, some do not go into deep trance and yet respond adequately to suggestions.

Suggestions made during trance may help to break old habits

like smoking, nail-biting or thumb-sucking. But these suggestions have to be repeated for a long time.

Hypnotic trance may help to uncover deeply buried memories or help the individual to recover from amnesias of different kinds.

Hypnosis is quite effective in the treatment of symptoms of hysteria. If the therapist makes forceful suggestions that his symptoms will disappear they do disappear. But this treatment is only very superficial and does not go to the root of the trouble.

Hypnosis may reduce or remove pain, and operations have been performed in trance states.

Hypnotic treatment also helps to remove tensions and give great relief and relaxation.

Under hypnosis suggestions are made to the subject and he relives an emotional experience he has had in the past which may be associated with his present symptoms. The idea is that such experience should be reintegrated with the normal life of the individual so that he understands its relations with his present attitudes.

### *Value of hypnosis*

As has already been pointed out hypnosis as a technique of psychological treatment is quite effective in dealing with patients of hysteria suffering from amnesia. In hypnotic trance he is able to recall lost memories or memories which were repressed, and these memories are carried to the waking state by means of post-hypnotic suggestions. Paralysis of parts of the body, deafness or loss of voice are cured by making suggestions while in trance which are to be implemented in the post-hypnotic state. Other helpful contributions, to the treatment of psychoneurotic trouble by hypnosis have been detailed in the previous section.

Sigmund Freud too employed hypnosis in psychotherapy but he later discovered that the use of hypnosis to remove symptoms was only temporarily effective. It was superficial and touched only surface symptoms. The symptoms would return soon enough or arise in another form. Therefore, Freud discontinued the use



of hypnosis in psychotherapy. Another drawback of hypnosis is that it can be used only with those persons who are capable of being hypnotized and who have no objection to being hypnotized. There are many people on whom hypnosis has no effect, they cannot be hypnotized. Some people do not wish to be hypnotized and you cannot hypnotize a person against his wish. Lastly, some neurotic patients may retaliate against the hypnotizer by bringing a suit against him for using them unfairly. These criticisms have to a large extent reduced the popularity of hypnosis as therapeutic technique.

Hypnosis should be used by a trained person. In the hands of an untrained person it may be ineffective or even dangerous. But it should be clearly understood that if a hypnotizer makes unfair use of hypnosis, that is, makes improper or immoral suggestions, it is most likely that the subject will refuse to obey him or co-operate with him. But even then a hypnotized person is liable to be deceived and used as a pawn by the hypnotizer.

### *Experiments in hypnosis*

Recently a number of research experiments in hypnosis have been carried out by Erickson and others and they have led to a better understanding of the working of hypnotic trance and have greatly increased our interest in hypnosis. In some of the experiments carried out by Erickson he tried to investigate the possible anti-social use of hypnosis. He asked one student to read his roommate's letters. After many failures the experimenter was able to persuade the student in the trance to open the letter of a roommate. The student would look at the blank side of the letter or place it upside down or make excuses that he did not have his glasses and later that the writing was too difficult for him to read. When the experimenter persisted the student developed blindness and could not see at all. From this example Erickson makes out a case that it is difficult to persuade the hypnotized subject to act in anti-social manner.

### *Narcotics in psychotherapy*

For long it has been known that under the influence of alcohol and other narcotics people have revealed their inner

conflicts, their repressed wishes and other concealed aspects of their personality. Barbiturates have been employed in psychiatry but the most popular narcotics to be used are sodium amytal and sodium pentothal. The patient is made to recline very comfortably on a cot and as the needle goes in for an intravenous injection the patient is asked to count backward from a hundred. The injection is continued until his counting becomes confused. The needle is then withdrawn and the patient is given interview. Under the influence of the drug he talks very much and even of very trivial and intimate things. Soldiers returned from the battle are told that they are again in the battle and they begin to talk of things which shocked them with as much emotion as they originally aroused. By reliving such experiences they are able to adjust themselves to them, to accept them and to feel less shocked by them. The repressed emotions are expressed, pent-up emotions are released and the symptoms which they had caused are to some extent relieved.

It is obvious that such a treatment can be given only by a specialist trained for the purpose. He must during the narcosis interview, guide the patient so that he carries out suggestions in later waking state.

## QUESTIONS

1. What is a case history? Give a detailed description of what is included in it.
2. What sort of psychological and physical examination should be given to a neurotic before actually treating him?
3. What is the place of advice, exhortation and persuasion in psychological treatment? Discuss.
4. Define hypnosis, and describe hypnotic behaviour. What is the value of hypnosis in psychotherapy?
5. Describe in detail the technique of hypnosis. Of what use is it in psychological treatment? What is post-hypnotic suggestion?



6. What is the procedure of using narcotics for psychotherapy and what is the value of such a course of treatment?
7. Distinguish between :
  - (a) Directive and non-directive therapy.
  - (b) Surface and depth therapy.
  - (c) Psychotherapy and psychiatry.

## Psychoanalysis

In this chapter we shall discuss psychoanalysis and related techniques of treating psychoneurotic troubles. But as psychoanalysis also stands for certain theories we shall deal with them to present an integrated description of the views and methods of Freud and his followers.

*Catharsis*

Since long even laymen have held that if a person in grief or misery is encouraged to talk out the burden on his mind this by itself will relieve him considerably. Today it is an important preliminary procedure of relieving tensions and mental difficulties. *Catharsis* consists simply in talking out troubles, worries and conflicts, it is a discharge of emotional tension associated with painful or embarrassing experiences by unburdening the mind in talk. This may be achieved through drugs, hypnosis or interview. Page calls it a form of "medical confession" in which the mind is relieved of "painful, guilt laden or distressing secrets". Patient sympathetic listening goes a long way to relieve tensions provided there is no element of ridicule or criticism while listening.

Catharsis has one great advantage. If we have done anything shameful it is much better to live with it and accept it rather than pretend that we did not do it. And talking about it places it in an objective view.

Catharsis may take several forms. People may be asked to act out in a dramatic show the ugly embarrassing situations in which they were placed in the past. This is called *psychodrama*. Then there is play therapy in which patients take part in games and other recreational activities so that their anxieties, worries and conflicts are discharged into physical activities. But such cathartic measures touch but only the fringe of the problem. It is true that they offer relief and reduce emotional tension but the important thing is that the individual should live and work



with self-confidence and courage so that he does not commit past mistakes again. To achieve that more sustained psychological treatment is called for.

### *Psychoanalysis*

Psychoanalysis is a prolonged treatment which, as has already been stressed, only the rich and the leisured class can afford. The course of treatment may extend from two to four years with daily sessions of a couple of hours. It includes free-association, dream-analysis and reconstruction of the whole personal mental make-up of the individual. The aim is to uncover the unconscious and bring to light the long repressed infantile sexual wishes, and to so re-direct thinking and mental energies that the life of the individual becomes more constructive and positive.

The term "psychoanalysis" is used in three different senses. Firstly, it is used for a school of psychology which emphasizes the dynamic aspect of behaviour, the role of the unconscious determinants of behaviour and the importance of early childhood experiences in moulding and affecting adult human personality. Secondly, psychoanalysis is used for a special technique of the science of psychology in investigating and studying unconscious mental activities. And thirdly, it is used as a method of studying and treating mental disturbances, particularly the psychoneuroses.

The founder of psychoanalysis was Sigmund Freud whose contribution to psychology and abnormal psychology has already been briefly indicated in the chapter on historical introduction. The views of Freud have been vehemently criticized and his followers in different countries have modified his methods and theories considerably. These too have been mentioned in that chapter. Here our scope is very much limited and we are concerned mainly with psychoanalysis as a method of psychological treatment of mental disorders.

The objective of psychoanalysis as a method of treatment arises from the psychoanalytic theory of mind and personality. According to Freud, as has been previously stressed, there are three parts, levels or spheres of the mind. The Id consists of the primitive inborn impulses, it is the sum-total of persistent, unconscious,

infantile, pleasure-seeking and hostile impulses. The Super-ego consists of the functions of conscience, ideals, self-criticism and self-observation. These two groups of forces are always in conflict, and the function of the ego is to try to make his lot bearable and to consider the claims and demands of both the objective outside world and of the two masters, the Id and the Super-ego. Repression is conveniently followed by the ego and all sorts of compromises are made resulting in psychoneuroses. The aim of psychoanalytical therapy is to strengthen the ego by having it reclaim portions of the Id and becoming independent of the tyrannical demands of the Super-ego. If the unconscious hidden impulses of the Id could be reconciled with the demands of the Super-ego and the outer world, the patient will face life more serenely and his neurotic troubles will end. This means that the repressed experiences, wishes and efforts of the individual must be brought to the conscious level. This is easier said than done for these memories are very unpleasant and painful and cannot be recalled directly. The main purpose of psychoanalysis is to break down the barriers which prevent such unconscious impulses to enter the conscious life and uncover them in such a manner that the individual will not be unduly shocked and will accept them as his own. It is claimed that the individual recovers when he recognizes them and accepts them.

As has been already pointed out psychoanalytic treatment is not within the reach of everybody. It involves daily sessions with the therapist for five days in a week over a period of two to three years. The average length of treatment is nearly two years. Besides this length of time the question of expense is no less important. Even if the therapist charges ten rupees per day, it comes to fifty rupees a week and several thousand rupees over a period of years. Obviously enough everybody cannot afford this. Psychoanalysts are very strict about punctuality and fees because they think that the treatment will not be effective unless the patient takes it very seriously and is made to pay through his nose.

Once the patient agrees to be treated he is not allowed to discuss either the symptoms of his treatment with anybody else, to read books or pamphlets on psychoanalysis or to have any sex



relations. In the course of his treatment the patient is asked to recline on a couch as comfortably as he can and the analyst sits at the head of the couch so that he can watch the patient without being observed by him. The emotional reactions of the patient are observed but the emotional reactions of the analyst are not seen by the patient.

Not all patients are equally benefited by psychoanalytical treatment. Four things must be found in a patient who can be successfully psychoanalysed :

1. He must be willing to be treated. Some patients have such an exaggerated sense of self-importance that they would prefer to handle their difficulties by themselves.
2. The patient must be intelligent enough to understand that his difficulties may have emotional causes and to understand the explanations offered by the analyst. Feeble-minded people are not capable of deriving any benefit from psychoanalysis.
3. The procedure and the course of treatment should be suited to the needs of the patient and the nature of his illness. In between, hypnosis or stay in a hospital may be necessary.
4. The life goals of the patient must be good and if they need to be changed the patient must be willing to change them. He may be very intelligent but may not care to have cordial relations with people around him.

We shall now describe some of the important items in the technique of psychoanalysis.

### *Free-Association*

The patient is asked to tell the analyst everything that comes to the mind of the patient, regardless of the fact that it may be embarrassing, foolish or indelicate. These thoughts usually concern the events of the day, his complaints, his reactions, dreams and fancies. These are interpreted by the analyst to the patient as showing his general approach to life and his reactions to his problems and difficulties.

Lying on the couch the patient lets his mind go as it were. It is only when he is relaxed that this activity of "free-association" has full play. This is different from any serious action undertaken by him. His thoughts and feelings are determined by the mood of the moment and the mood is similar to one obtaining in day-dreaming. He expresses his fears, hopes, anxieties, wishes, angers, freely and they guide his thoughts and feelings.

As we have pointed out the individual in trying to defend his self-esteem, represses his embarrassing, painful and shameful thoughts and wishes and any attempt to uncover such repressed hurtful memories and conflicts calls for his *resistance*. Freud put forward the method of free-association to overcome or get around the individual's resistance. Letting the patient's mind wander, uncontrolled, and to express his thoughts and feelings as they arise in his mind, the individual is able to discard shame, embarrassment, and his desire to make a good impression.

The patient does not respond to the call of the analyst at the first interview but he learns only gradually to reveal himself. At first he may run out of associations, stop day-dreaming and begin to talk about unimportant things; in some cases patients begin to abuse the analyst or cancel his treatment; a patient may even claim that he is cured and does not need any more treatment. Such resistance on the part of the patient only shows that he is becoming aware of the conflicts in his mind. This resistance is an indirect confession of his secrets. It is at this time that the analyst has to be careful, to explain to the patient that he is resisting because of deep conflicts and urge him to overcome them.

Usually when the superficial stock of memories is exhausted the patient begins to talk of inner impulses, buried memories and phantasies.

### *Dream-analysis*

Another tool in the psychoanalytic procedure for uncovering the unconscious is dream-analysis. Dreams are psychological products which represent a person's reactions to his daily experiences. Freud calls dreams "the royal road to the unconscious". Dreams reflect unconscious conflicts, express repressed unful-



filled wishes and thoughts. During the day physical and social environment, social pressures like moral standards, etiquette and considerations of decency do not let us give expression to many ugly, embarrassing and unpleasant thoughts and feelings, but in sleep this censor is removed and the repressed unconscious wishes and desires have a free play. The ego is less vigilant and repressed wishes, feelings, thoughts and memories enter into consciousness in the form of dreams.

The psychological forces expressed in dreams are mostly emotional and irrational. They are of the type which would be forbidden in normal waking life. They are of hostile and sexual character which would bring shame, fear, and humiliation. That is how we have nightmares. But though vigilance is relaxed in sleep it is not altogether absent. That is why the contents of dreams are expressed in a disguised form so that the sleeper may not wake up. The disguised aspect of the dream is called the *manifest content* and when the individual recalls it on waking up he does not attach any meaning or importance to it. But to understand the real meaning, we have to look for the *latent content* of the dream. This is done by asking the patient to give his free-associations to the manifest content items.

The manifest content is the dream as it appears to the dreamer and the latent content is the symbolic meaning of the manifest content. The manifest content is phantastic and bizarre but it symbolizes certain things when given close study. Once this symbolism is understood no dream appears absurd. Any fact which stands for another fact is a symbol, white is a symbol of purity as red is a symbol of passion. Dreams are usually symbolical. Freud contended that some symbols are universal but most of his symbols are associated with sex. Berg Louis in his book *The Human Personality* gives examples of common Freudian symbol meanings.

“Symbols have both a racial and an individual basis ; many are based upon myths, legends, folklore and the common archaic material of the race. But above all we must recognize that most often we deal not as much with individual symbols—which are few in number—as with racial symbols. The thigh, the staff, and the snake are well recognized universal symbols for the phallus (the

male organ) and for the associated qualities such as power, domination and procreation. The male organ is not infrequently referred to in conversation as a staff, the physical similarity making it a convenient symbol for those ignorant of or ashamed to use the scientific term. King and queen stand for father and mother ; parting is the symbol for death".

"A house is a fairly well known dream symbol for the body—the 'house' of the soul : thus a tall building in a dream refers to a tall person, a low building to a short one. The foot is a phallic symbol as seen in dreams. Although it may mean speed and power, also it has, in the myths of the race, come to stand for fertility. The gods are frequently pictured making corn, wheat, and flowers grow where their feet have trod upon the earth. Civilized man, with his fitting of the feet with sandals or shoes, has created the archaic value of this sexual symbol."

"Fire is frequently a symbol of love. In our minds the implication of passion is heat : we speak of people aflame with love, compare love to a fire that burns freely and then dies down." The lion is a universal symbol for courage ; the tiger for ferocity of attack ; the oak for sturdiness. There are linguistic connections between symbols and the idea they call forth in a dream ; thus a man who thinks himself as fast on his feet, dreams of a race between two deer in which the smaller one wins. The explanation is that he is a small man who symbolizes himself as quick as a deer, and that he conquers his opponent in real life, *through* a dream".

Dreams are subjective and though the individual may dream of other things and beings he is the central figure in every dream. He is the centre of activity and it is to him that something happens.

Dreams are imaginary wish-fulfilments, and the great majority of them are fulfilments of sexual wishes. By "wish" he means all kinds of motives. Thus he uses both the terms "sex" and "wish" in the broadest sense possible. Other psychologists do not agree that these terms should be so used in an unrestricted sense.

Dreams of frustration may be interpreted as repudiating oneself. A person with a high sense of ambition and independence may dream of his failures and defeats. A woman who thinks her-



self independent of male help may dream of taking help from another man. It may also be that dreams of frustration or of danger may be safeguarding reactions. A person may dream of running after a train with his brother, and missing it though his brother who is a poor runner catches it.

Dreams never lie. The meaning of the dream is always true of the dream in its fundamental sense. The dreamer who failed to catch the train was found to be unable to persuade himself to get married. His failure in marriage was symbolized by missing the train. Dreams give a true picture of the person's strivings and wishes.

Fear and anxiety dreams are common to both children and adults. Such fear and anxiety is a continuation of fear and anxiety found in real life. The individual may have experienced great fear and anxiety in waking life. Dream-life is a mere replica of the waking life. People with courage who are able to meet the dangers and difficulties of life squarely seldom have fear and anxiety dreams. On the other hand those who have inadequate control over fear and who have frequent fear experiences during the day carry over their fears and anxieties into dreams. They repeat fear and anxiety in order to gain mastery over them.

Then we have protest and escape dreams, dreams being left without clothes or of being naked. Freud interprets such dreams as indications of a tendency to exhibition but this explanation is rejected by others who contend that such dreams have only egoistic motives and may be of the nature of protest against social restraints and controls.

Dreams of falling, flying or levitation have always been cited for comment. It is assumed that the sense organs with which such dreams are associated have something to do with dreams. They may have been indirectly stimulated in sleep. The flying dream is interpreted as stimulated by respiration, the rise and fall of the chest in breathing. Another psychologist interprets flying dreams as due to very rich and varied mental activity.

Again there are dreams about events which are yet to take place and many people have attributed prophetic value to dreams. This is only speculation. That in dreams we surmise certain future

events does not really justify the conclusion that all dreams have a prophetic value and can forecast events. No doubt we can make a very good guess of future events on the basis of present facts, but this really not enough reason to believe that future events can be foreseen in dreams. Thousands of events happen in dreams which never come out true but a few that come out true should not be made the basis of a general claim. In any case the data is not sufficient to justify a universal proposition that all dreams forecast events as many women very naively believe. They do not take into account numerous dreams which never come out true.

Dreams have offered solutions of baffling problems of personal nature which we have to solve or deal with in our normal waking life. In our waking life our thoughts, feelings, and reactions are determined by the outside world and our immediate environment. But in dreams the environmental factor is absent. In one dream a woman reported that she dreamed of getting married to her husband, the marriage ceremony started and then suddenly all faded away. Such a dream is an unsuccessful approach to her unhappy marriage. In her dream she was merely reviewing the incident of her marriage and stating quite clearly that if she had all her own way she would not marry the person who is her husband. In fact she was in love with another person whom she could not now marry—a dream never lies.

### *Dream mechanisms*

The problem is how is the real meaning of the dream, that is the latent content, converted or distorted into the manifest content, that is, the dream picture as it occurs? How does the latent content come to be symbolized into the manifest content? This is called the mechanism of dream formation and its understanding will help a better study of the close relationship between the manifest content and the latent content.

*Condensation* means a fusion of many ideas into one. In dreams a single element in the manifest content may stand for a number of elements, wishes or wish objects, in the latent content. Missing a train in a dream may represent failure to utilize an opportunity for employment, defeat in a match or failure to



marry. All these incidents have been condensed into the manifest content of missing the train.

*Displacement* means that an affect or emotion often becomes displaced, that is, attached to an unimportant element of the dream from an important element in waking life. This helps to disguise the latent content of the dream and gives it a fantastic and bizarre appearance. Sometimes this displacement takes place with the opposite elements so that the dream comes to have just the opposite of its real meaning. For example we may dream of being extremely kind and sympathetic toward a person though in waking life we dislike him most. Such a dislike would belong to the unconscious.

*Dramatization and visualization* is obvious enough. We all know that most of our dreams are in visual imagery and the events in a dream have a dramatic look. Thoughts, feelings and actions are dramatized in visual imagery. The individual lives out or acts out his experiences, his desires and wishes symbolically and in imagination. Since most of these wishes were repressed in childhood, there is regression to childhood and that is why most of our dreams are in visual imagery.

Not all dreams can be analysed. The analyst is sometimes unable to construct a sound interpretation of the dream situation. The dreamer may find it difficult to reveal all his attitudes. It is not possible to find out for sure that everybody dreams every day. Recently with the help of electroencephalogram it has been possible to indicate that at least some periods of sleep are dreamless. But it is very well known and accepted that a person may dream and not remember it. Very often people say certain things in dreams which other people hear and which they themselves on waking up are unable to remember. Nor is it possible to indicate the duration of a dream with certainty. But on the basis of evidence that is available it can be said that a very large amount of happenings are covered in a very short period of dream.

### *The analyst*

During psychoanalysis the therapist is the most important person for the patient. The relation between them is similar to the child-parent attachment. The analyst wins his confidence and the patient comes to rely on him, and naturally there grows a

sort of attachment between the two. The patient has to make confessions of childhood sexual experiences and the therapist is the most important person for the patient. He understands all, knows all, and forgives all. He may become a father substitute for men and a lover substitute for women. This is *positive transference*. Before psychoanalysis is completed this relationship must be dissolved. But the therapist must avoid this. He should not be deeply interested in his patients so as to get involved emotionally with them. For moral considerations and for the success of his therapeutic programme he must avoid *counter-transference*, that is, emotional involvement in the patient.

During the treatment the analyst lets the patient talk most of the time. In fact 95% of the talking is done by the patient. The analyst only patiently listens to his fears, hopes, anxieties, sins and conflicts. He makes no comment, no attempt to convert the patient, to ridicule, condemn or punish the patient. His main function is to help the patient to self-understanding by making him fully aware of the primitive impulses of the Id and the ideals and goals laid down by the Super-ego and the demands of the outside world. He will try to find causal relations between the fund of material offered enabling the patient to work out his own loves, hates, and fears.

The analysis is stopped whenever the patient thinks he has had enough or the analyst decides that the patient is incurable or has acquired sufficient understanding and mastery over his difficulties and symptoms.

### *Evaluation of psychoanalysis*

Although comparatively few psychologists accept all the ideas, terms and procedures of Freud they readily acknowledge that he was a great thinker who brought about a great revolution not only in psychological study but also in other social sciences like sociology, literature, politics and anthropology. We are concerned here with the value of psychoanalysis as a method of treatment.

The practical usefulness of this method of treatment is obviously very much limited. One restricting factor is the high cost. A thorough treatment costs a tidy sum as has already been pointed out. Secondly it needs a lot of time to be treated this way. How



many people can afford to spend one or two hours every day for at least eighteen months, and a very hard working therapist cannot hope to treat more than five patients in a year. In view of this great burden of expense and time, many analysts have resorted to what is now called *hypoanalysis*. Hypoanalysis is adopted as a means of speeding up the formal treatment through psychoanalysis.

*Hypoanalysis* has been described as analytical psychotherapy carried out under controlled conditions, that is, under hypnosis. At special stages in psychoanalytical therapy hypnosis is used to break through strong resistance more quickly or to uncover repressed material. In this way it is possible to shorten the time required for a psychoanalysis. But it requires a highly skilled therapist. In this approach the hypnotist acts as a guide to lead the patient through a large mass of unconscious material. He must know in what direction to look for significant facts and how to handle transference.

In the course of treatment by hypoanalysis the first fifteen minutes of daily session are devoted to free-association. The patient is then hypnotized into a trance and given various suggestions to facilitate the recall of repressed or early experiences. Such suggestions as are given during the trance may be acted upon in the post-hypnotic state and thus the patient may recall on waking up from the trance his early experiences. Thus any resistance he may have to open up his mind to the analyst is broken down, and he is stimulated to re-live his emotional experiences of early days, to describe related dreams and the like.

Information obtained in a trance is interpreted in the trance so that he may not have any difficulty on waking up. Even then some experiences and thoughts of the trance are carried over to the waking state and promote understanding of the problem. But if necessary hypnosis can be suspended. But it is as yet too early to assess the value of hypoanalysis.

Another limitation of psychoanalysis is that everybody is not amenable to this technique. A suitable patient for this technique must be sufficiently intelligent and must have strength of character to respond favourably to this technique.

It is difficult to say if psychoanalysis is more effective in the

treatment of psychoneuroses than other simpler methods but the percentage of cases successfully treated by psychoanalysis is about 65%.

But the best evaluation of the technique of psychoanalysis is given by Fr  ud himself. He regarded most of his ideas as theories rather than established facts. He frankly admits "I have made many beginnings and thrown out many suggestions. Something will come of them in future."

We shall now deal with other types of treatment of mental disorders.

### *Educational therapy*

In a sense all therapy is educational in so far as it contributes to the development and re-education of the individual towards healthy and normal ways of thinking, feeling and behaving. All psychotherapy aims at helping the patient to find and understand himself and reconstruct his emotional attitudes for better and more stable adjustments. But here we will deal with specific educational procedures which help to cure some of the mental difficulties.

*Reading* books, pamphlets and magazines the patient finds out that he is not the only unique sufferer and others too have similar problems and difficulties and how they deal with them. Often in reading novels one comes across characters who have had similar frustrations and anxieties and then he tries to meet his difficulties in the same manner. Then there are books dealing specifically with problems of mental health, how to achieve peace of mind or make one's mind strong, and they give us helpful guidance in the solution of our problems.

Then even formal education may involve the learning of social skills, dancing, good manners, acquiring good taste in dressing and eating, talking and decorating one's home. All these help to make life pleasant and provide opportunities for self-expression and creative activity which make life more zestful and happy.

### *Occupational and recreational therapy*

The use of occupational and recreational therapy has been found



very valuable in the treatment of psychoneurotic troubles. They help to socialize the individual and give him something useful and pleasant to do so that his mind and attention are diverted away from his symptoms. Even many hospitals have regular social events like movies, dancing, teas, musical concerts and the like. These help the patient to feel less lonely and isolated and bring them out of their shell of self-sufficiency.

Games and sports are also arranged and in addition to providing physical exercise they increase the social feeling. Competition and co-operation in various teams give a feeling of group-belonging and help healthy adjustments to people and life.

The use of music in psychotherapy is very important and must be emphasized. Music involves a variety of emotional effects, it soothes some and excites others, but all in all, it stimulates us to activity and self-expression as few other media do. Many people after listening to good music are tempted to sing and dance, and stimulating music has tonic effects. Investigations made show that it helps to increase group feeling and strengthens inter-personal relationships. We all know how exhilarating folk music is, and however different may be our training folk songs have an appeal which surpasses that of chamber music.

Art and crafts also afford rich opportunities for self-expression. They not only keep the neurotics busy and occupied but help them to express their feelings and give them experience of success and accomplishment which will boost their morale and inspire them with courage and self-confidence.

### *Hospitalization*

Staying in a hospital not only provides great opportunities of medical and psychological help and treatment but also removes the patient from depressing life and situations in which he has met only with frustrations and defeats. With proper diet, rest and exercise the patient feels greater courage and confidence in solving his problems. Mental hospitals and clinics in the west provide a variety of mental and physical activities which are very helpful in bringing the patient round to a better approach to his difficulties.

The most important feature of hospitalization is relaxation



and rest which softens the tensions and conflicts of patients. In fact, all therapists recommend complete relaxation for the neurotic and relaxation therapy has been accepted in its own right as a kind of effective treatment.

### *Psychotherapy according to Adler and Jung*

Psychological treatment offered by Adler is simpler and more direct. The first step is to discover the style of life of the patient, the particular goal of superiority he has chosen for himself. For this a detailed case history is prepared, his fears, hobbies and social habits, organic defects and inferiority complexes are given very close study to find out the psychological pattern of his life. His dreams, mannerisms, his likes and dislikes reveal a great deal about his specific problems, and dreams suggest the solution to his problems. The patient's way of talking, standing, walking and his social behaviour in general shows what sort of person he is, what are his goals in a general way and how he is trying to realize them.

After finding out his style of life he should be guided to know and understand the real nature of his symptoms, what purpose his symptoms serve, how his goals are unreal. The role of the therapist should be that of a friendly and affectionate guide, even as a father or elder brother is. To be cured he must give up his too high goals and try to live with smaller achievements. He must change the style of his life and direct his interests and efforts to what is within his reach and capability. Conversation method will help to encourage him to express himself freely as also to guide him to a better way of living and thinking. The aim of Individual Psychology as Adler's school is known is to re-educate the neurotic patient to a new style of life and socialize him in such a manner that he feels greater self-confidence in coping with his problems and difficulties.

Adler's approach is a commonsense approach, it is direct and simple, rational and understandable. But are human maladjustments so simple as that? Are they amenable to such a simple treatment? While Adler's approach appeals more to educators and social workers, Freudian methods have opened the eyes of many medical men to new vistas of treating mental disorders.



Jung who put forward his Analytical Psychology which is a mixture of empirical observation, mysticism and religion, argued that there are four stages in the treatment of psychoneuroses. They are confession, explanation, education and transformation. Confession means that he should recall not only past experiences but mostly his emotions. It should recall whatever the patient felt and thought in the past. Free-association and dream-analysis will be employed to help him bring up his buried past. Jung has strengthened free-association with word-association test of 100 words chosen for their possible emotional significance. One word is presented and the patient is asked to give the first association that comes to his mind. Record is made of the reaction and its speed. Word-association helps to bring out the contents of the unconscious. For Jung the dream has several meanings. It may express suppressed wishes of the past, a manifestation of present conflict or a foreshadow of things to come. Jung seems to favour the view that dreams are prophetic in nature.

As treatment proceeds the therapist explains to the patient the meaning of the material he has recalled and of his dreams. Jung is of the view that dreams are related to primitive psychology, mythology, or comparative religion. The patient is helped to assimilate into the conscious what he has recalled from the unconscious and to break down the barriers between the conscious and the unconscious.

In the third stage an attempt is made to socialize the patient so that he has a new outlook on life, to re-educate him in such a manner that he does not run away from life or withdraw from reality. He should accept death as a goal and not shrink from it.

Jung thinks that the teaching of many religions that there is a life after death is conducive to mental health. People who have hope of a life after death feel normal about it.

The last stage of transformation is more complex. It involves adapting treatment to the particular needs of the patient so that the therapist faces the same task as the patient of getting over the troubles of the latter, and of changing the patient into the type of person the therapist thinks the patient should become. The therapist may have to change himself too in the same direction so that he is an example for the patient to follow.

*Some theories of dreams*

We may end the chapter by discussing some other important theories of dreams. Freud's theory has already been discussed in detail and also comments on its value have been made.

*The perception-illusion theory of dreams:* This is one of the oldest theories of dreams. According to this theory the dream is a response to various stimuli which are acting upon the individual during sleep. Usually when a stimulus is presented its sensation through association leads to some comprehension of its meaning, but in sleep the paths of association are blocked and the sensory stimulation follows the path of least resistance, producing such associations as have been frequently, strongly and recently found in experience of waking life. The dreams may be described as free-association, undetermined by any purpose, interest or awareness of the external world. That is why dreams are absurd, phantastic and bizarre, meaningless and incoherent. If while sleeping the pyjama string gets underneath the body the individual may dream of a snake or a rope. It is common knowledge that people have suffocation dreams if their hand is left on the chest during sleep or a heavy covering gets folded many times on the chest in sleep. If a few drops of water are sprinkled on the face the dreamer may dream of having cold drinks with friends on a hot day, of being caught in a torrent of rain or taking a bath in a river or sea.

But such a theory cannot explain all the facts about dreams. In the first place why should the dream be so much distorted or misinterpreted? Why should not the physical stimulus be perceived as it is? Why should an individual continue to have the same type of dreams again and again? If the dream is a misperception or just an illusion why should it take the same form again and again? It is obvious that there are some deeper psychological forces at work which determine the character of the dream. Why should a mother shriek at night again and again that her son is being taken away or a young man dream of missing a train time and again or a servant dream of his master's death? This theory is unable to account for this phenomenon. If external stimuli determine our dreams, there must be some quantitative relation between the two but obviously there is none. If a light



stimulus produces a strong perception, a pin-prick makes us dream of being killed with a sword or an axe there must be some other factors at work.

*Dream as an apperceptive "trial and error" process :* According to this view the dream is a response to a peripheral stimulus and in the dream this stimulus is interpreted in a number of ways. There is a large mass of ideas in the sub-conscious and some of them are a possible solution or interpretation of the stimulus. One after another is tried but they are rejected one after the other. That is why the dream picture is fluid and changing, incoherent and absurd. This theory suffers from those very defects which have been cited against the previous one. Why should the individual try to interpret every stimulus that comes his way is not clear.

#### *Freud's theory of unfulfilled wishes*

Freud's theory of dreams has been discussed in its various parts and aspects in previous sections and chapters. Here it may be briefly mentioned that Freud attaches too much importance to two concepts, sex and wish, and uses them in a very generalized sense. Not all dreams are sexual and not all dreams are wishful. Repression occurs due to conflict between the Id, that is, primitive instincts, on the one hand, and Super-ego, that is, moral ideals on the other. Having been repressed the sex instinct is unable to gain expression in its natural form and seeks expression in disguised form in dreams. The dreams are just one way of seeking expression, the other forms in which such unfulfilled sex wishes seek expression into consciousness are mental disorders, day-dreaming, autistic thinking, slips of the tongue and the pen, art and literature.

#### *Adler and Jung on dreams*

According to Adler dreams supply valuable information about the style of life of the individual, his social habits. They reflect current and future unsolved problems and offer suggestions for their possible solution. For him the main problem of psychotherapy is to re-orient and re-educate the individual and transform him into a new person. Dreams supply valuable data toward this end. A constant conflict is going on between two principles,

strivings for superiority or the desire for power and mastery, and the feelings of inferiority or the fear of failure. These two principles are basic to all human behaviour and dreams offer solutions of conflicts between the two. They tend to harmonize our ambitions with facts of reality.

According to Jung dreams are a voice of the unconscious and may have several meanings. They may express the repressed wishes of the past, they may express the present difficulties or they may foreshadow the future. Thus Jung subscribes to the prophetic view of dreams. He sees in dreams conflict of the two basic trends in the individual, the progressive or the forward trend and the regressive or backward trend. Human energy or libido takes a regressive or backward trend when it fails to find an adequate outlet for its adaptive thinking and behaviour. Then it resorts to primitive or infantile ways. The dream is an example of this. Jung also puts forward the theory of the collective unconscious which is found in the forms of the myths and beliefs of ancient people. There is a close relationship between the latent content of dreams and the collective unconscious though the individual is entirely ignorant of it in his waking life.

## QUESTIONS

1. What is catharsis? What is its therapeutic value in abnormal behaviour?
2. What is psychoanalysis? Describe its basis and methods. What is its value?
3. What is the value of free-association in psychotherapy? How does Jung supplement it with word-association?
4. What is the value of dreams in psychotherapy? What is the nature of dreams? How is dream analysis helpful?
5. Describe the nature and advantage of hypnoanalysis.
6. Explain education therapy and recreation treatment.
7. Discuss the several theories of dreams and bring out in detail Freud's theory of dreams. What is the validity of his theory?



## General Introduction to Psychoses

*What is a psychosis?*

A psychosis is a severe mental disorder in which personality is disrupted and in which the individual has seldom any understanding of his mental disease, in which his behaviour is bizarre and absurd, his thoughts and beliefs are based on delusions and his emotions are so disturbed that even those who do not have any knowledge of psychiatry or mental disorders can easily perceive that he is sick. A psychotic person has lost all contact with reality and suffers from all sorts of delusions and hallucinations. Such a person has to be lodged in a hospital for his own safety and other people's convenience, for he is incapable of looking after himself or his affairs or of making social adjustments.

Psychoses are generally confused with insanity on the one hand and dementia on the other. In modern usage insanity is mostly a legal term implying that a person adjudged insane is not legally responsible for his actions. Many criminals offer plea of insanity to escape the clutches of the law. Dementia is a term which implies degeneration of mental functions of very severe type. Some psychoses have symptoms of dementia but not all psychoses are marked by it.

We have already discussed the general characteristics of psychoses and compared them with psychoneuroses. We may recount some of the prominent symptoms of psychoses. The behaviour of psychotic patients is absurd, peculiar and annoying. They may injure themselves and they may do harm to others around them. Socially and emotionally a person suffering from a psychosis is greatly disturbed; he is depressed, irritable and fearful or he may be suicidal, suspicious, ready to attack others or absolutely indifferent. His thoughts and ideas are confused, he suffers from delusions and hallucinations. His speech is blocked and he is incoherent and indistinct. He may have lost his memory. He may be too active or utterly inactive.

What percentage of the population above 15 years is afflicted with psychosis? No figures are available in this country, but on the basis of admissions into mental hospitals in the United States it is estimated that 8.5 per cent or 1 out of 12 of all persons born will at some time in their life develop psychotic reactions and will have to be placed in hospitals for mental disorders.

### *Types of psychoses*

It is usual to classify psychoses into two groups. *Functional* psychoses are characterized by severe psychological stress and originate from it; *organic* psychoses arise from brain pathology, some organic defect in the brain together with severe mental stress.

Functional psychoses may be divided into three groups :

1. *Schizophrenic disorders* in which the individual withdraws from reality altogether, his emotions and thoughts are greatly disorganized, and delusions and hallucinations are present in large number and complexity. It has further sub-types which will be described later.
2. *Paranoid disorders* in which the person has delusions that he is being persecuted or that he is some very big personality, but his personality structure is intact.
3. *Affective disorders* in which there are extreme changes in mood with related disturbances in thought and behaviour. It has three sub-types : maniac depressive, psychotic depressive and involutional melancholia.

Organic psychoses are constitutional and some organic defect or toxic pathology is present. These disorders are known as *toxic* and *organic*, and include senile dementia, psychoses with cerebral arteriosclerosis, general paresis and alcoholic psychoses.

Approximately one-third of patients of mental disorders suffer from functional psychoses and one-third from organic psychoses. The other one-third are difficult to classify.

### *General factors*

These mental disorders do not occur at any and every period of life. They have their own peculiar stages in which



they are generally found. Schizophrenia or *dementia Praecox* as it is called is a disease of the adolescence and early adulthood. Maniac depressive and alcoholic psychoses and general paresis are found mostly in middle age, and involutional melancholia are found mostly in the latter part of the middle age.

This peculiarity that certain mental disorders are found at certain periods of life is very interesting, and has strengthened biological interpretation of mental disease.

The number of male admissions to mental hospitals is higher than those of women at all age levels, but the incidence of mental disease among women is higher than men. May be because women in general live longer than men.

The factors of intelligence are not important in the incidence of mental disease. The psychotic patients reveal a wide range of intellectual ability, and intelligence tests do not reveal any marked differences in them. Every type of psychosis is found in various grades of intelligence.

Economic status does make a slight difference. This is in line with the general truth that physical, mental and social disorders are more frequent among slum dwellers.

Considering the number of admissions in mental hospitals they are more from towns than from villages. May be that people in villages have more space and are more emotionally tied to the members of their families to send them to mental hospitals.

No racial or cultural group is free from mental diseases. They are found in every race and every stratum of society. In the United States it has been observed that mental diseases are far more common among Negroes than among whites. It may be that habits of drinking are far worse among them and that their economic condition is extremely bad.

### *Some misconceptions*

In the first place admissions to mental hospitals should not be taken as a measure of the incidence of mental disease in any country or community. In India social conditions are such that people have a deep prejudice against sending one of the

family to a mental hospital. Usually they are kept at home even though it is not possible to give them enough attention. And then mental hospitals are few and far between, and not within easy reach of villages and small towns. Nor are conditions in mental hospitals very attractive, and leave much to be desired. Accommodation is limited and the facilities are very meagre. Therefore, increase or decrease in the admission to mental hospitals should not be taken as a measure.

It is too easily assumed that mental disease follows a breakdown in business, disappointment in love, death of a very dear relative or some other form of emotional stress of great severity. This is not quite true because most people do experience very severe emotional stress at one time or the other of their life but only a few develop a psychosis. This shows that there must be some other factor working to bring about psychosis. In the two world-wars many army personnel suffered from serious mental trouble and it was certainly brought about by the battle conditions but it is no less true that a large number of army people were not affected at all. It is difficult, therefore, to put it down to any one condition as the sole determinant of the psychotic trouble.

Another prejudice is that modern civilized life is very fast and full of tensions and stresses and, therefore, the incidence of mental disease is greater in modern civilized society than it was in the primitive society. But considering the large numbers of incidents of witch-hunting described in ancient history one may reasonably conclude that no period of history or no cross-section of mankind has ever been free from mental disease or disorders.

Again there is gross misunderstanding about the nature of the psychotic patients. Most of them are believed to be violent and dangerous who may commit murder in any way or manner. This is far from truth. Only a very small minority of psychotics are so inclined and a large number of them have no such tendency. Rather they are very docile and harmless unless they are provoked.

Nor are they very abnormal in their sex relations. Where abnormal sex relations are found they are due mostly to basic disorganization of personality rather than any psychotic trouble.



In one study it was found that abnormal sexual behaviour is seldom the cause of psychotic troubles. On the other hand most married psychotics have had unhappy married lives. Happy married life discourages the development of psychosis.

There is a general misconception that genius is a type of mental disease. Let us consider it in detail in a separate section.

### *Genius and mental disease*

There is a very popular notion that genius and insanity go hand in hand. While the view is entirely disowned by psychology the relation between genius and insanity may be dealt with in detail so that the misunderstanding is dispelled.

Several studies have been made of genius in several areas of life and work, and it has been concluded on the basis of that evidence that mental derangement is not a peculiar characteristic of genius. There is no doubt that pseudo-artists and people who have done some outstanding work in any field are often found to be a little queer and temperamental, and may develop psychotic reactions but true men of genius are on the whole less prone to them than the rest of the population. Let us bring up evidence for and against the problem.

It is common knowledge that artists may be very neurotic and a good many of them are not able to meet the demands of social reality. They, therefore, develop symptoms to protect themselves against such conflicts. Most artists are rebels, they do not conform to social norms in dress, appearance or even gait, social standards are utterly ignored by them, their temperaments and conflicts are very much similar to those of the neurotics. In fact conflicts which produce works of art also lead to neurotic symptoms. Many geniuses have suffered from psychosis and neurosis. Nietzsche suffered and died of paresis. Von Gogh suffered a severe schizophrenia and died in an asylum. Poets and painters have always been known to be weak on wine and women. Such instances have created the widespread impression that genius is neurotic and psychotic.

On the other hand Havelock Ellis who studied 1,030 men of eminence in Great Britain found only 4 per cent to be mentally ill and Cox who studied 300 geniuses supports Havelock Ellis.

Thus while the incidence of mental disease in general population is 8.5 per cent among geniuses it is only 4 per cent. Rather people who may be described as genius and developed psychotic reactions later in life were less eminent and their mental illness came on in old age. Those who did develop some neurotic or psychotic reactions were either poets or writers, very few were men of science. Insanity makes people lose their genius and cannot exist side by side with superior mental gifts. Here and there an exception may be found of one who did his masterly work during his mental illness but in a general way it can be claimed that great many cease to be creative and productive after or during mental illness.

#### *Are mental patients curable ?*

Too many people believe that mental patients are incurable. This is only partially true for hospital figures from the United States show that 50 to 60 per cent are discharged from mental hospitals on recovery in about two years' time or so. Some have needed longer period of time but there is no doubt that there have been remarkable cases of recovery even in advanced mental diseases and even after several years.

#### *Treatment of psychoses*

Patients of psychosis must be treated in a hospital. This applies not only to patients who are prone to injure themselves and others around them but also to those who are harmless and only queer in their behaviour. Patients of psychoses are unable to look after themselves and manage their own affairs, and their stay in the family is a heavy strain on other members. In a hospital they get regular treatment and the right type of atmosphere suited to the needs and condition of the patient. But above all and more than anything else treatment in a hospital is much less expensive. But among Indians there is a strong prejudice against sending their relatives to a mental hospital but it is not appreciated that often patients need impersonal care in which there is no emotional outburst. The treatment of psychotic patients is generally of prolonged duration and it is always better to place them in less expensive and more objective arrangement like that available in a hospital.



But the provision for mental hospitals in India is very meagre. In some States there is just one mental hospital which is not enough. Then most of them are very poorly equipped both by men and material. In some large towns like Calcutta there are some private houses into which psychotics can be admitted on a boarding basis but there is no regular programme for their treatment.

### *Medical aid*

Psychotic patients are as much exposed to illness as the ordinary individuals and regular medical check-up is very essential. In special cases a course of medicines and diet may have to be prescribed to correct digestive disorders, to improve appetite, check sleeplessness and relieve other physical troubles as also to improve general health.

Medical treatment of the mental patient will embrace practical branches of medicine. Sedatives may be required for over-excited patients, special diet for emaciated patients, brain surgery for tumour cases and so on. However, there are certain special medical techniques which are primarily designed for psychiatric patients and they are described here in detail.

### *Shock therapy*

One of the most important developments in psychiatry has been that of shock therapy in the treatment of functional or organic psychoses. It means the use of insulin, metrazol or electro-shock and these will be described separately. The term "shock" is a misnomer because all that these methods do is to induce a disturbed state of consciousness. In metrazol and electro-shock therapy or electric convulsive therapy (ECT) the disturbances in the state of consciousness are accompanied by convulsions. In insulin therapy convulsions do not occur, and if they do they are considered undesirable.

In insulin coma therapy the patient is given an injection of insulin strong enough to induce a coma which gradually develops in a few hours. This method of treatment was introduced by Sakel, a Viennese physician. The injection is given intramuscularly

and in a large dose so that the sugar content of the blood is reduced and a condition of coma is produced. The patient becomes increasingly drowsy, loses consciousness and gradually passes into a shock in which there is twitching of the muscles, intense excitement and great neurological disturbances. The patient may perspire profusely or may be quite dry. In some cases convulsions also occur. When the coma has lasted from fifteen to ninety minutes, it is terminated by giving sugar of glucose. How long the state of coma should last will depend on the judgment of the therapist. When the patient comes out of the coma he is in a better state of adjustment to his environment than he was before. This phenomenon does not last long but as the treatment proceeds this period of clearness becomes longer. The treatment is continued till the patient shows improvement, but usually it is not continued beyond sixty days.

*Insulin treatment* is of great value in the treatment of reactions of schizophrenia and affective psychoses. However, therapeutic opinion is veering round to the view that it is not so effective in the treatment of affective psychoses.

In big hospitals there are special wards for giving insulin shock treatment. On the first day the patient is awakened early and given an intramuscular injection of ten units of insulin. This dose is doubled every day till a state of coma is produced. The strength of the dose may go up to 1,000 units. Once a state of coma is produced the patient needs smaller doses on subsequent days of the treatment. In the state of coma he does not recognize stimuli applied to him such as pin-prick or speech. When the coma is over the patient is given a meal rich in carbohydrates and vitamins.

When the patient wakes from the coma there may be lucid moments during which he may see his surroundings clearly and may have no delusions, may get rid of his extreme suspiciousness or attitude of withdrawal from the objective world. He may suddenly become warm and affectionate and may begin to take interest in things and persons around him. At this moment his symptoms either disappear temporarily or are reduced. This moment does not last for more than an hour but as the treatment progresses it may grow longer till the patient finally recovers.



During this lucid period the therapist does try to establish a close and intimate relation with the patient so that he should be able to influence him in the interest of permanent recovery.

Latest reports from the United States show that 60 to 70 per cent of the patients of schizophrenic reactions recover with the help of insulin treatment but it is more effective if the schizophrenic reactions are not very old. The results are less favourable in reactions of longer duration. Patients of the age between 20 and 30 years respond better to this treatment. If the attack is sudden and acute due to some emotional shock like some sudden tragedy in the family then the treatment is more effective.

This technique of treatment does not involve any risk as hardly one per cent cases are fatal and they are also due to the inadvertence of the therapist who may prolong the coma longer than is really necessary. Insulin treatment should not be used on patients suffering from any heart disturbance or from diabetes, tuberculosis or serious organic defect.

Later shock treatment was conducted through the use of a convulsive drug *metrazol*. It was introduced by a Budapest psychiatrist, Meduna in 1935. This was a new approach in the treatment of schizophrenia. The injection of this drug produced convulsions. This method is very simple. The patient who has not taken his breakfast is given an intravenous injection of 3 to 5 cc. of a 10 per cent solution of *metrazol*. A few seconds later the patient becomes pale and rigid and often makes movements as if he were trying to escape. He then loses consciousness and begins to have convulsions as if he were seized by epilepsy. These convulsions last from 30 to 60 seconds. After the convulsion he feels confused and fearful and then goes to sleep. On waking up he has nausea and dizziness, headache and fatigue. Five to thirty injections may have to be given depending upon the improvement of the patient.

Convulsions in *metrazol* treatment are very severe and care has to be taken and the patient tied down to the bed and placing a gag in his mouth so that he does not bite his tongue or lips.

*Metrazol treatment* was introduced to treat schizophrenia but later it was found to be of less value than was claimed for the drug. It was found to be very useful in the treatment of affective

disorders in which the patient is greatly depressed or highly excited.

The use of metrazol is objected to on two serious grounds. In the first place patients object to it because it produces fear in the brief interval of injection and the loss of consciousness. Patients get very nervous as to what is going to happen to them. Secondly unless great care is taken to tie the patient down to the bed there is a danger of his dislocating or fracturing the spinal vertebrae and arms and legs.

At the present time, though few psychiatrists believe that we have a completely specific remedy for schizophrenia, few hospitals maintain an insulin unit, and those that do seldom use it to capacity. There are plenty of reasons for giving up insulin coma treatment at the first sign of a simpler remedy of comparable usefulness. Both insulin and metrazol provide a definite rate of mortality, they tied up many nurses and doctors day in and day out, and with an average course of forty to sixty comas, it took many weeks to complete, and so when electro-shock treatment was introduced in the nineteen-thirties there was a move to stop or reduce the use of insulin coma therapy, until it was found that the indications for the two treatments were different. No controlled experiments have ever been carried on about the use of insulin or metrazol treatment. Only *ad hoc* comparison between cases who had received the treatment and those who had not was made, but in such a comparison other incidental factors were never considered. Those who criticized and condemned insulin treatment could not get any hearing because psychiatrists were not prepared to give up the only technique they had for fighting schizophrenia and the critics had no alternative to offer. Later tranquilizers were introduced and insulin treatment was stopped at many hospitals.

Meduna's metrazol treatment by inducing convulsions caused greater and greater agitation as the level in the blood rose, until a fit caused loss of consciousness. The method produced results promising enough, in those days when there was hardly any effective treatment for mental disease, to force the psychiatrists to use this method, but probably no treatment has caused so much fear in the heart of the patient. One frivolous objection against



it was that it was so terrifying that even a psychotic would deny his symptoms to get off the treatment list. In 1937-38 the method of producing fits by the brief passage of an electric current across the temples was introduced by Cerletti and Bini and the treatment of psychosis by convulsions became at once less cumbersome and more humane.

The *electro-shock therapy* is also a technique of artificial production of convulsive seizures by passing a measured electric current through the brain. A number of steps are taken to safeguard the patient against injury during the convulsions. Curare is ordinarily used to relax the patient and reduce the possibility of fractures, and rubber gag is placed between the teeth to protect both his tongue and teeth. He is placed in a bed which is insulated and relatively hard. Electrodes are fastened on the temples or the head. Then a current usually in the range of 300 to 1200 milliamperes is passed through the cortex for a period of 0.2 to 0.5 seconds. The patient feels no pain and the convulsions which follow last from 30 to 60 seconds and are similar to a fit of epilepsy. Then the patient remains unconscious for about 10 to 30 minutes. On waking up he feels drowsy and confused, and may complain of vague pains and mild headache.

This treatment is given two to three times a week. Some patients show marked improvement after 2 or 3 sittings while others need up to 20 sittings. If there is no improvement after 30 or 40 sittings the treatment is given up.

Electro-shock treatment has proved of great value in the treatment of psychotic depressions, in maniac reactions and in certain selected cases of schizophrenia. Electro-shock convulsions are more easily controlled than metrazol convulsions and are less severe. They are not accompanied by fear and there is no danger of fractures, but the treatment of schizophrenia through electro-shock is ineffective.

### *Theories about Shock Therapy*

Many theoretical explanations for the effectiveness of the various forms of "shock" therapy have been offered. Psychologists hold that even the experience of fear has a curative value ; the



individual's consciousness is highly stimulated and reorganized, his forced return to his environment of things and persons and the individual attention he receives from doctors and nurses is of great remedial advantage. From a physiological standpoint it is held that "shocks" shatter the abnormal nerve pathways, toxic substances are made ineffective and any abnormality or degeneration is checked. But these are nothing more than theories, a sheer guesswork, and as has already been stressed treatment of psychoses is based on trial and error experience. The different shock therapies do injure some cells in the brain, impair memory and occasionally lead to death.

### *Frontal Lobotomy*

Frontal lobotomy or psychosurgery or any other name like neurosurgery means surgical incision into the brain in which nerve pathways between the cerebral cortex and the thalamus are cut. The original procedure advanced by Moniz consisted in making two openings in the skull, one on each side above the temple and then cutting through a measured section of the nerve fibres connecting the frontal lobes with the thalamus. Such an operation is called frontal lobotomy or leucotomy. Since then many modifications have been made and now the procedure is known as *psychosurgery*. Variations are made in the size of the holes that are cut and the place where they are cut. Different procedures have had different results, and they are used in patients suffering from schizophrenia and severe psychoneurotic disturbances.

In some cases there have been temporary or permanent complications such as increased appetite, convulsions, aphasia.

The most important effects of these operations is in the area of personality change. If successful the operation checks the great emotional tension and anxiety characteristic of many patients but this decreased tension is accompanied by loss in the depth of personality and superficial or shallow emotions. In varying degree these patients become cheerful or indifferent to the feelings and opinions of others. They tend to live in the present with little regard to the past or the future. They generally forget the past and are no longer aware of themselves as they were before. Some people after the operation become childish, immature, more



suggestible, with less emotional restraint, and may have to be re-educated. They are no longer concerned about their bodily condition as they were before, pain does not worry them or distress them as it did before the operation. Thus the claim holds that psychosurgery releases the patient from worry, anxiety, inhibitions and depression. Those who were painfully self-conscious, sad and worried become cheerful and carefree. Some become indifferent to social norms, are indolent and lazy, but many are able to make very suitable social and occupational adjustments. In cases of agitated depression or involutional melancholia it has proved very useful.

Frontal lobotomy is a mutilating procedure in which some parts of the brain are made ineffective or by damaging some parts of the brain anxiety, tension and self-awareness are removed.

#### *Narcosis therapy*

Narcosis therapy is sleep therapy and by means of sedative drugs like sodium amytal prolonged sleep is induced. It was in 1922 that Klaesi introduced prolonged sleep as a method of treating mental disorders. The patient is made to sleep for 15 hours and roused only for bath and meals for a period of 15 days or so. During the Second World War exhausted patients were given this treatment fairly successfully. Although this treatment is very mild very careful medical aid and nursing is very necessary so that there may be no complications of cardiovascular nature. Narcosis therapy is very effectively used in the treatment of maniac-depressive psychosis and in controlling intense excitement. In the case of other psychoses and particularly schizophrenia it is of practically no value.

#### *Physiotherapy*

Physiotherapy means the use of several physical things to treat mental disorders such as water, heat, electricity or massage, for their tonic effect and relaxation.

The use of water is *hydrotherapy*. Continuous hot baths with the temperature maintained at 100 degrees are widely used to calm down and relax highly excited and agitated patients. A special tub is used through which warm water at a constant temperature

flows continuously. In other cases when patients are noisy, tense and excited cold or hot wet packs may be used to calm them down according to the needs of the patient. Alternate hot and cold showers are given for their tonic effect. This natural and harmless treatment is preferred to the use of drugs in quieting down patients.

In electric treatment heat is applied by means of infra-red lamps, electric heaters and diathermy. This is quite effective in cases of nerve inflammation and the like.

The value of massage in stimulating different limbs of the body and for its tonic effects has been long recognized, and the personal contact in massage is also of great psychological value.

### *Occupational therapy*

In modern hospitals mental patients are not allowed to sit idle and brood away their time. They are kept occupied in some work of stimulating and pleasant nature. If they are physically healthy their mental health is promoted by vigorous exercise or work which involves it. Such work cheers up the depressed, wakes up the indifferent and provides a healthy outlet for the over-active. Work is not only worship it is also a very healthy and wholesome method of spending time and exercising both mind and body. Another advantage is that it detracts the attention of the mentally ill person from the symptoms.

### *Recreation*

It is an old truism that good cheer and enjoyable work keeps a man healthy and happy and to some extent mitigates the harshness of his symptoms. Recreation is an important item in a well-balanced life. Library facilities, indoor games, radio, movies and parties all are helpful in any hospital. They also help to promote healthy social life so that when the patient is discharged he has no difficulty in meeting and working with people in the world outside.

### *Psychotherapy*

It is a cardinal principle in psychiatry that causation is always multiple, physical, constitutional and psychological so that



every course of treatment to be complete and ideal must take into account all the factors. It should never be unitary. Most of the psychotic patients are so insulated from the rest of the world by their psychotic ailments that psychotherapy has no effect or value for them. But there are a number of psychotic patients who are helped by talking things over with a trained psychotherapist. We have emphasized the psychosomatic or psychobiological approach a number of times in this book. Obtaining a complete history of the patient and talking to the patient and his relatives one must get at the root of the basic problems and difficulties of the patient and form a comprehensive picture of the total personality of the patient in its entire social and cultural setting.

A number of techniques of psychological treatment have been described in a previous chapter. A trained psychiatrist will select some or all of them according to the needs of the patient. All that is emphasized is that psychological treatment may be found necessary in some psychotic cases, at least to supplement other modes of treatment.

### *New drugs in psychiatry*

Drugs used in the treatment or control of symptoms or eradication of diseases are now so many and diverse that any general account of them must be very selective and determined by their therapeutic values rather than by their chemical, pharmaceutical or structural interest. These drugs may be divided at the very outset into two groups—those which are used in treating schizophrenic reactions and those which are used to elevate the mood, the anti-depressive drugs. The former are phenothiazine drugs such as chlorpromazine and the latter are imipramine compounds.

The anti-schizophrenic drugs are mostly known as tranquilizers, a name which is both unhappy and incorrect. They are derived from two main sources, one from phenothiazine and the other group is derived from the Indian climbing shrub *Rouwolfia serpentina* or other closely related shrubs.

Several compounds were tried and for psychiatry the compound chlorpromazine turned out to be crucial. Its sedative effects were found to be more striking than any other compound. But it



had action in several other fields including anti-adrenaline, temperature reducing and nausea preventing, and the capacity for prolonging the effect of other sedatives. In the fifties there were other sedatives strong enough to combat over-agitation, over-excitement and destructive tendency but they posed an insoluble problem as they also produced dangerous unsteadiness of gait or other toxic effects. To counter these side-effects injections of morphia had to be given. The use of chlorpromazine solved this problem. It is a powerful sedative and led to very favourable results by showing great improvement in psychiatric patients. It has great capacity to calm without clouding consciousness and to relieve the symptoms of acute schizophrenia. But so great is the power of fixed ideas that it was also included in the class of "tranquilizers". Psychiatrists wanted to do away with this term but failed. One reason is that chlorpromazine in action is very successfully used in the treatment of schizophrenia whatever the symptoms. If they consist of over-activity it tranquilizes, if they consist of under-activity it activates. Thus to call it a tranquilizer is not correct.

The effects of this drug have been found to be very far-reaching. While milder cases of patients were treated well in hospitals the more serious cases were neglected and led a formless life. This drug calmed without inducing sleep and had remarkable cures to its credit in severe cases of schizophrenia, the disappearance of its symptoms, it made withdrawn and unapproachable patients warm and affectionate so much so that even other patients were affected by their cure. Patients who had been incontinent regained control of their functions and destructive patients stopped tearing away their clothes.

But drug trade has produced so many compounds that psychiatrists have to take pains to sift the genuine from the fake.

From *rauwolfia serpentina* is derived the drug reserpine. In India it has a long reputation for curing several ills including those of psychiatry. At first it was used for high blood pressure but later on it was found to be quite effective in quieting agitated patients. It was given a psychiatric trial in the late fifties and its curative effects were close to chlorpromazine and in combination with these drugs became the main remedy for schizophrenia.



The evaluation of these drugs was done under variable conditions and it was in the course of this evaluation that doubts were aroused. It was argued that in the case of some long neglected patients any drug would be effective and they began to talk of the *placebo effects* of a drug.

### *Placebo responders*

Whatever the kind of treatment a doctor may give to the patient the latter believes that he is receiving a purposeful treatment, and is usually attended by some improvement. In the special case where the treatment is scientifically useless this beneficent effect, which follows with gratifying frequency, is called a *placebo effect* and the treatment is called a *placebo*. Those who have experience of systematic psychotherapy will bear testimony to the effect that some patients recover before the therapist has had time to decide what technique of treatment he should follow. The most common placebos are pills and medicines. Even genuinely effective medicines have a placebo effect along with their own effect. Many people who cannot sleep drop off to sleep long before the pill has had any effect showing thereby that the sleep is not a significant response to the drug.

Before scientific medicine came into existence almost every drug was a placebo and therapeutic benefits occurred despite the objective inefficacy of the drug. Not only doctors but even patients are dimly aware of this fact. Many patients point out the colour of the medicine and feel that the medicine must be effective because it is very bitter. Many doctors keep the drugs changing or give too many medicines to exercise this placebo effect. They may not be clearly conscious of the placebo effect of their technique or action. Today doctors are equipped with highly efficacious medicines and control pain with anaesthetics but some may have observed that they can render the patient anaesthetic even by a lesser dose because their own presence and operation-room atmosphere adds the placebo effect to the effect of the reduced dose. Professor H. K. Beecher of the Harvard University studied the placebo effect quantitatively, with special reference to its effect in pain. According to him it was generally found that more than one-third patients suffering pain responded satisfactorily to inactive

drugs, and even with other symptoms the same proportion responded satisfactorily if they were really anxious to get well soon. There is a widely quoted description of placebos : "the ideal pill was as red as possible, as bitter as was compatible with ingesting it successfully, as complicated to take, as possible (i.e. take two pills with one-third of a glass of lukewarm water six minutes before each main meal, except on Tuesdays), and as unlike the familiar aspirin tablet as the maker could manage."

Psychiatrists were rather late in recognizing this placebo effect and making use of it. Placebo responders are benefited even by inert drugs is a fact which later psychiatrists have exploited most blatantly. There is great scope for it too because in mental treatment the relation between the patient and the therapist and the rapport that is established between the two is most important. Physicians have found that even in cases of very clear causation like pneumonia the placebo effects are not altogether absent.

Experiments have shown that a person who responds to the placebo effect of one drug usually responds to the placebo effect of another drug also. Such a person is likely to be extraverted, co-operative and uncomplaining and his illness is likely to include strong but vague anxiety about his symptoms.

In the investigation of the efficacy of many drugs this placebo effect has to be considered very seriously. In the response of patients to any drug that is tried allowances must be made for placebo effect. If the patients selected for trial of any new drug is a placebo responder the conclusions regarding the effectiveness of the drug are sure to be obscured. To overcome this difficulty psychiatrists had to devise methods of drug trial which should be steered clear of the placebo effect.

### *Future of chemotherapy*

The treatment of mental disorders by drugs, that is, chemotherapy, has a bright future for research and investigations have just begun. Some drugs have toxic effects, others have side effects which must be avoided. All this must be guarded against. Chemists and pharmacologists must work in close cooperation with trained psychiatrists. The progress may be slow but there is reason to



hope that depression, morbid anxiety, over-excitement and agitation already susceptible to relief will yield consistently to new and improved drugs, since drugs are already known that induce these symptoms.

## QUESTIONS

1. What is a psychosis? Describe the several types of psychoses.
2. What general factors work in psychoses? Discuss some of the common misconceptions about them.
3. Is genius a kind of mental disease? All genius is mad, discuss this critically.
4. Discuss the various techniques of shock therapy and evaluate them.
5. Describe physiotherapy and frontal lobotomy. How far are they effective?
6. Discuss the value of some of the important drugs used in psychiatry. What is the future of chemotherapy?
7. What is a placebo effect and placebo responder? Discuss the phenomenon of placebo in drug investigation.

## The Functional Psychoses—Schizophrenia

Schizophrenia is the most common form of insanity. Its characteristic symptoms used to be generally placed under the term *dementia praecox*. Dementia means loss of mind and is a common term used for the progressive degeneration or decline in mental functions which means deterioration in attention, in memory and in reproductive imagination, in judgment, in initiative and industry and in social aptitude and adjustment. The patient may become slovenly in physical traits and careless about bodily functions. As the dementia progresses such latent traits as dishonesty, cruelty and sexual depravity may be enhanced. Dementia accompanies many mental disorders and there may be many types of degeneration. The word *praecox* means premature. Thus dementia praecox means decline in mental functions which begins early in life, i.e. in a youthful period of life. The term was first applied by Morel in 1860 to a thirteen year old boy who was a most brilliant pupil, but who lost interest in studies, became withdrawn, seclusive and quiet, forgot all that he had learned and frequently talked of killing his father. Morel thought that his mental, moral and physical functions had declined and he was incurable.

In 1911 a Swiss psychiatrist Bleuler rejected the term dementia praecox and instead used the term *schizophrenia* for this disorder. Schizophrenia means a splitting of the personality but, of course, this splitting takes place only in theories of psychiatrists. The implication is that there is a split in his thoughts, they do not cohere or hang together, and there is a split between his thoughts and behaviour. He has peculiar ideas about himself and his environment, and behaves in many respects without any reference to his delusions. He may, for example, think that he is Shivaji and still continue to work as a gardener. Schizophrenia is just a common name for being crazy. The split occurs in the sense that his delusion of being Shivaji has nothing to do with his regular work as a gardener. One may say that this splitting is just an alternation, the patient has delusions at times and at



other times he is quite lucid. This split or alternation or gulf becomes wider as the disorder becomes worse. The most striking features of this mental disorder are general psychological disharmony, lack of feelings and emotions, lack of coherence and system in thought processes, absence of social understanding and adjustment, delusions, hallucinations, and peculiarities of conduct.

*Nature of schizophrenic reactions or symptoms of schizophrenia*

How does a person suffering from schizophrenia behave? What are his symptoms? This question is easier to ask than to answer for patients of this disorder display a large variety of reactions and traits and the general terms in which they are described are capable of a large variety of meanings. We may try to classify them or place them under general headings.

*Emotional disorders:* This is perhaps the most common symptom of schizophrenia. Patient's emotions are dulled and he feels indifferent and apathetic toward his external environment including other individuals. McDougall thinks it is the only important characteristic of this disorder. The patient does not consciously display or experience keen and adequate emotions, and does not seem to comprehend joy, sorrow or fear. His emotional behaviour is most unnatural and it is difficult for any normal individual to establish friendly rapport with him. He may talk of death or disaster without feeling any regret, sorrow or grief; he may claim to be a genius or a great man without any excitement or joy. There is an utter lack of feeling for people around him. If people around feel grief and shed tears, if they are excited over the success of their children or if they are frightened by a great fire, he is untouched and unmoved. His sensibility is dead and his emotions are blunted. Sympathy, love or fellow-feelings have no place in his life.

A patient of schizophrenia is a withdrawn solitary person who has no social feeling and who keeps staring in the vacant space. If he is obliged to work his output is very slovenly and poor. As his trouble worsens he loses interest even in his own bodily needs and may starve or die of thirst if there is nobody to look after him. If he is placed in a group he takes

no interest in others, does not exchange any conversation with them nor try to know or learn about others.

The emotional responses of schizophrenics are not specific. They are more of the nature of general excitement. They at one time get excited and talk loudly and vehemently, and at another remain quiet and silent. Without any apparent cause they may start giggling, crying, getting angry or attack a person standing by. There is no joy in their laughter, good news does not please them and misfortune does not depress them. If they injure anybody they feel no remorse. Their emotions if they ever occur have no relation to their environment or situation. Some of them do feel fear, even panic, in expectation of harm from their persecutor. Their emotional responses may occasionally be fused and they may feel joy and sorrow together, weep with eyes and laugh with the mouth. But it is best and most correct to say that they have no specific emotion and all that they feel is diffused vague excitement which may be interpreted in more than one way.

*Delusions* : Like dreams of a normal person the delusions of a person suffering from schizophrenia are of illogical, fantastic situations in which he may consider himself to be some grand eminent person or to be persecuted by some imaginary enemy. His mind is not hampered by rules or logic nor does he see reason. Like dreams he has fantastic ideas of reference and grandeur and believes that he is a man of great influence and power. Or that somebody is reading his thoughts and controlling them and his movements. Ideas of influence are expressed when the patient says that someone puts thoughts into his head, influences his actions, causes him discomfort and pain by influencing the working of his organs and limbs. Such an influence is often described as hypnotic.

A schizophrenic patient may also complain that some enemies are trying to do him harm. He may believe that some secret agents are after him and wish to destroy him, that some deadly poison is being mixed in his food or that some poisonous gas is being let loose in his room. He may even complain that his room is giving out some deadly smell which is sure to kill him. Some



patients have delusions that somebody is always following them, has evil intentions against them and will pounce upon them at some ripe moment.

Ideas of grandeur or eminence are manifest when the schizophrenic boasts of some mysterious quality in himself which will do wonderful and remarkable things. If anybody questions him he will say that he has a mission in this world and will do something remarkable in life and that he was born to serve humanity and the like.

Some schizophrenics believe that they are Nehru, Gandhi or Kalka Mata but these boasts are not accompanied by any emotions of elation or joy. And these thoughts are not organized into any system nor is there any consistency about them. Often their statements are self-contradictory, their attitudes are conflicting and their emotions are of both love and hate.

*Hallucinations* : Often these delusions are accompanied by hallucinations. They hear strange voices, someone asking them to do something great and grand. It may be the voice of some supernatural being, of some dead relative or of somebody whom they have known. They may see non-existent objects outside. These hallucinations are much more common in schizophrenia than in any other mental disorder. The voices that patients hear may be flattering, abusing, or threatening and they may be from God or man. Visual hallucinations are also common but they do not persist. They are just fleeting and dim, and occur for a very short period. Sometimes they see God, angel, or some big person or report that they have seen stars or bright light giving them a message. Or some dear dead relative is reported to be giving them orders or commands for doing certain things. These commands vary and there is no consistency about them. Messages from secret organizations are also reported.

But hallucinations of smell and taste are also present though they are less frequent. The patient complains of a bad taste in the mouth or of poison having been mixed in his food. He may also complain of very bad smell which is that of a poison. He may complain that somebody is trying to kill him with poisonous gas which is all over the room. There have been cases in which

the patient has complained of sexual assault or somebody pinching his leg or arm.

*Speech disorders* : Many changes in speech are also observed in schizophrenic patients. They may become quite mute and avoid saying anything. In some cases this muteness is due to their retreat from the outside world and lack of interest in their surroundings. They do not speak because they have nothing to say. Or may be that they have heard a voice asking them not to speak. Some may not be speaking because they are afraid that they will have to open their mouth and somebody may try to poison them. And some patients of schizophrenia are over-talkative but their speech is incoherent, there is lack of proper inflections, they may speak very vehemently and talk about their troubles. You may ask them one thing and they give you an absolutely irrelevant reply. "What is the day today?" The reply is "yes" or something which cannot be understood. Even if what they speak looks or sounds like a sentence the words are jumbled and unconnected. Such incoherent speech is the result of disorganized processes of thinking and feeling. Often people around think that the utterances of a patient of schizophrenia are full of profound meaning and wisdom, but it is nothing of the kind. It is mere chance word associations. Often new words are coined. Such neologisms have no rationale behind them. Some new words are just fusions or mixtures of common words and some have no observable source or origin and are intelligible to the patient alone. The patient may invent a complicated language but it can be understood only after equally complicated analysis.

*Changes in behaviour* : The patient's posture is rigid and constrained. There is no expression on his face, no emotion and no thought. His looks may be described as quite vacant. There is no mobility in his expression. He may smile or frown but he does so in a very silly manner. He may frequently cough or spit, rub his hands or legs, twist his hair. If any person around him puts him in any posture he maintains that posture for long. The arm or hand may remain lifted for a period of time without any fatigue. He may never ask for anything to eat. If he is asked to change his posture or given some command he will not obey, rather he will seem not to have heard it. He may keep looking



at some fixed spot as if he has something very meaningful to see or he may remain in a listening posture as if he is listening to something very significant. May be he is having hallucinations of sight or hearing.

*Disorders of thinking :* Incoherent speech, irregular behaviour and disorganized emotions are evidence of disorganized and bizarre thinking. A patient of schizophrenia does not think in the sense that there is no continuity, unity or organization in his ideas. He has no purpose. He seems to be flitting from one idea to another, there is no connected chain of thought. He may concern himself with any particular sensation from any part of his body or he may be preoccupied with any minor physical trouble, and then he brings up any irrelevant explanation of that trouble.

Several theories have been offered to explain this thinking disorder. Some think that his associative connections have become weak or loose, while others hold that a patient of schizophrenia regresses to childhood or primitive forms of thinking. In support of the latter theory it is argued that a schizophrenic thinks in terms of concrete things rather than abstract ideas. Their explanations of things and problems are in terms of the concrete rather than in abstract thinking.

*Decline in intelligence :* There is great impairment of intelligence and the mental disorder decreases the mental efficiency of the schizophrenic patient. But all mental functions are not equally impaired. While memory and abstract thinking are very much disturbed there is less disorganization of vocabulary. But the loss in intellectual functioning is not permanent and with the regaining of mental health intellectual functioning is restored to its original condition.

However, an average schizophrenic is aware of his identity, knows his whereabouts, recognizes people and is able to give his address and tell the day or the date. Memory for early experiences of pre-illness days is normal but for experiences during illness is very disturbed. But he has no knowledge of his disease or condition.

*Physical health :* A patient of schizophrenia has poor physical

health for want of proper exercise, nutrition and rest or sleep. He is usually pale and weak.

### *Clinical types of Schizophrenia*

Four varieties of schizophrenic reactions are generally recognized, but these should not be considered fixed for one patient may have reactions of more than one type or the dominant symptoms may vary. They are *simple schizophrenia*, *hebephrenic schizophrenia*, *catatonic schizophrenia* and *paranoid schizophrenia*, and are described in some detail in these sections. The different forms are not mutually exclusive and they are distinguished on the basis of their predominant symptom or group of symptoms.

Which of these types is more frequent? The paranoid variety is most frequent, then comes catatonic, hebephrenic and simple types in this very order. The catatonic type is found more among women than men and the other types are more prevalent among men.

The different types of this mental disorder have independent origins. One distinguishing characteristic is age. At the time of admission to hospitals, the average age of simple, hebephrenic and catatonic schizophrenia patients is between twenty-five and thirty whereas the age of paranoid patients is between thirty-five and forty. Paranoid patients are usually well-built as compared with patients of other types.

### *Simple schizophrenic reactions*

The patient of simple schizophrenia has absolutely no interest in himself or in things and persons around him. Lack of interest, apathy and indifference is the distinguishing feature of this simple type. He wants to be left alone, if an attempt is made to incite him to activity he will soon after relapse into utter inactivity. He is content to remain in bed day and night. He neglects himself, does not mind being unclean, has no desire to take bath or to dress himself in clean clothes. His movements are sluggish and slovenly. Personal appearance and hygiene are of no concern to him. He withdraws from his environment of things and people into his own shell, does not engage in any conversation and if he does talk



it is about trivial things, has no interest in the opposite sex and cannot concentrate on anything except his phantasy. He is apt to sit in the same place by himself, with vacant expression or a foolish smile. He has no sense of responsibility, no interest in personal reputation, welfare of himself or his family or in events in the world around him. In this type delusions, hallucinations and peculiar actions are not found.

In simple schizophrenia there is some awareness of time and place and mental functions are not seriously impaired. If he is carefully treated at this stage there is likelihood of his recovering.

Often members of the family start arguing with the patient, advising, lecturing and encouraging him to engage in something worthwhile but this approach only makes the patient withdraw from them and his environment or at best develop a negative attitude, an obstinate and evasive response to whatever he is told.

Most patients of simple schizophrenia are kept in the family and may be able to get along with simple mechanical work like clerical job or manual work, but they make no progress and will not care to change or improve. They would like to be left alone.

There are many simple schizophrenics among prostitutes, vagrants, and criminals.

The onset of simple schizophrenia may be gradual or sudden. If it is gradual the future patient begins by losing interest and ambition and developing indifference and apathy, with a tendency to remain silent and reserved for a long time, keeping to himself, remaining depressed and reviving interests of childhood days. When the onset of the disease is sudden, the individual becomes ill suddenly, his body temperature rises, he becomes excited and possibly delirious. Hallucinations and delusions may be present but they tend to disappear as the disease becomes more severe. Later he settles down to a routine without any interest in his work and without any ambition.

The patient of simple schizophrenia looks so normal and yet something seems to be lacking.

### *Hebephrenic schizophrenia*

A patient of hebephrenic schizophrenia is distinguished from

other types by incoherence of thought, queerness of behaviour, bursting suddenly into tears and laughter without any reason, mannerisms and lively hallucinations. Besides there is shallowness of emotions, delusions of persecution or grandeur and the patient frequently fluctuates between depression, excitement, and stupor. There is gross disorganization in personality, speech is confused and frequent changes of emotional state from giggling to angry outbursts or crying and screaming. The patient takes no notice of his surroundings and may spend hours talking and smiling to himself or talking to imaginary persons. In the early stages of the disorder the patient may be engaged in conversation but his replies are irrelevant and meaningless. His writing is also confused. And both speech and writing being jumbled and confused thinking must be incoherent and disorganized. Words are mixed and there is confusion of thought. Thus silliness in thinking, feeling and action is in ample evidence.

Delusions and hallucinations are common. He hears voices which accuse him of dirty things and call him by filthy names. Delusions relate to sex, religion, hypochondria or persecution and are changeable and fantastic. He may begin by saying that somebody is persecuting him but go on to abuse him or try to fight that imaginary enemy. He becomes hostile and aggressive. He may shout and curse and make gestures of fighting.

Patients of this type of schizophrenia are not concerned about how they look, they have no interest in personal appearance, hygiene or decency and they may expose themselves shamelessly without any regard to what people are present. There is great instability of character.

### *Catatonic schizophrenia*

This type of schizophrenia almost always develops suddenly, in fact much more suddenly than the other forms of schizophrenia, but the patient generally has a history of some degree of indifference and apathy and gradual withdrawal from reality. In catatonic schizophrenia the patient alternates between excitement and stupor. In fact patients are classified on the basis of stupor and excitement. The onset of this type of schizophrenia is generally marked by headache, sleeplessness, loss of appetite and



the like. The important symptoms are negativism, catalepsy, suggestibility, stupor, excitement, mannerisms. The stupor in catatonic schizophrenia is accompanied by negativism and muscular tension. When the disease worsens the patient simply lies still completely, makes no response if spoken to or sometimes even if he is pinched or a pin is thrust into his skin. He has to be very carefully looked after and may have to be forcibly fed. He is not only indifferent but also negative, that is, he will do just the opposite of what he is told. If you ask him to open his mouth he will shut it tight, if you ask him to show his hand he will withdraw it. Any attempt to make him do things or to move his arm or hand is met with stout resistance. He may stand or sit in any posture for hours. At another moment you may put his hand or arm in any position and he will make no attempt to change the position. It will be at your beck and call and will stay where it is placed. This is called catalepsy. With this catalepsy there is found the extreme form of suggestibility, the patient doing what he is told in a most mechanical manner. This condition is also accompanied by *echolalia*, that is repeating what questions you ask or what observations you make or he may repeat the movements made in his presence, which is *echopraxia*. If they see a soldier they will stand erect and rigid like him.

The catatonic stupor makes the patients bed-ridden, mute, helpless and totally withdrawn from people around them. They refuse to eat and are generally very unclean.

Their stupor is marked by great rigidity. They may lie so still and rigid that they can be placed like a plank of wood on two chairs. If any attempt is made to bend them they will resist it strongly. If they clench their fist it is not possible to open it. Other type of catatonic stupor is marked by extreme flexibility, you may bend their limbs as you like without meeting with any resistance from them and the posture in which their limbs are placed will be maintained for hours.

It is common to distinguish between two kinds of stupor : *Benign stupor* and *Malignant stupor*. The former is associated with delusions of death, the patient either waiting to be put to death or believing that he is dead already, but in the case of the latter there are in addition limitations of energy, emotions and

thinking, inexplicable giggling or outbursts of rage, delusions other than those of death and jumbled speech.

After a period of several weeks or months the catatonic stupor changes into a normal state or passes into the other extreme of catatonic excitement. Catatonic excitement is very peculiar. The patient is in constant motion though he stands fixed at one place. This is extreme psychomotor activity. Though this excitement may show resemblance to the excitement of a maniac-depressive patient, the movements have neither any rhyme nor any reason, they are not directed to any definite end, and frequently show a great deal of repetition. Thus the patient may make the same movement over and over again almost endlessly, swaying the body back and forth, swinging his arms in a certain fashion, shouting the same thing again and again. This tendency to repeat speech or movement is characteristic of catatonic schizophrenia. His actions seem weird and meaningless because they have no relation to the external stimuli, but there is reason to believe that they may be induced by delusions, hallucinations and inner fears. They may become destructive and try to attack people around them.

Along with *echolalia* and *echopraxia* repetition of movements and speech, which have been described above, there is another tendency of *perseveration* which is frequently found in patients of catatonic schizophrenia. He may repeat persistently a certain movement everyday on seeing a particular person or object, he may draw the same picture everyday or repeat a senseless phrase persistently over a period of time. He may walk up and down the same path or describe a circle always when he is walking. This performance of stereotyped actions is called *stereotypy*. *Mannerisms* too are very common. He may swing one arm and hold the other tight, he may stand only on the left leg or walk close to the wall. If he is asked why he does these things he may reply that he does not know or that it is the will of God or give some other irrelevant or absurd reply.

A common reaction of this type of schizophrenia is cold and clammy and bluish extremities, ears and nose.

### *Paranoid schizophrenia*

The characteristic symptoms of this type of schizophrenia



are delusions of persecution, ideas of reference, ideas of influence, and emotional indifference and apathy. Often it is difficult to distinguish between paranoid schizophrenia and pure paranoia and certain patients may be classified into one or the other by different psychiatrists. But it may be said delusions of paranoid schizophrenia are more fantastic, less permanent and less systematized than those of pure paranoia. Besides in schizophrenia emotional apathy and indifference are very clearly marked. Schizophrenic patients have a clear history of lack of socialization.

Patients of this type are suspicious, sensitive, self-centred individuals who are victims of delusions of persecution. They believe that people are hostile to them and are working against them. They are plotting to take their life or devising ways to harm them. In the beginning there is a system in their delusions of persecution and they are confined to certain situations and persons but as the disease progresses their delusions become undefined and absurd. In the beginning they are very aggressive and would like to attack and destroy but as the disease advances their aggressiveness and assaulting spirit calms down.

Sometimes these delusions are supported by hallucinations. They hear the voices of their enemies calling them names and abusing them. They complain of poison in their food or smell poisonous gases in their rooms. They believe their enemies are all powerful and will destroy them. They may think of committing suicide to escape or try to attack others to defend themselves. Usually male patients have male persecutors and female patients have female persecutors. A paranoid schizophrenic may complain that his relatives and members of the family are keeping a watch over him, that they are trying to kill him by poisoning him or that they talk against him.

Alongside delusions of persecution there may be delusions of grandeur, they may believe that they possess remarkable qualities that they are being persecuted out of jealousy or envy. They may believe that they are one of the world's great men like Napoleon or Nehru or Krishan. Such delusions are accompanied by hallucinations. They may hear messages from angels or see visions all of which add to their grandeur. They may hear divine music or see divine light.

Because their world is full of delusions and hallucinations their judgment is impaired, their thinking is bizarre and uncritical, it is difficult to say what they will do next, and they may do something dangerous. They may break furniture or costly things or indulge in other violent acts. As their condition worsens with more delusions and hallucination their intellectual and emotional capacities disintegrate.

A patient of this type of schizophrenia requires hospitalization. The condition fluctuates, the patient may eat, speak, and behave better, and may even recover. He may adjust himself to his friends and relatives and even to his work. Frequently, however, the condition continues throughout his life and ends in total deterioration of his personality.

### *General dynamics*

Several studies have been made of patients suffering from schizophrenia and a large amount of research has gone into the search for causes or predisposing factors leading to this psychosis. But as the readers must have seen, the symptoms of several types of schizophrenia are of such a large variety that it is difficult to indicate specifically what factors lead to it. In fact any study of the several types of schizophrenia and its symptoms makes the reader doubt if he is dealing with one kind of mental disorder or different types of them. However, we may consider some important factors which may be responsible for it.

Let us consider first the *biological* factors. Several scholars at several periods of history have stressed the biological factors such as heredity, endocrine system or constitution as the basic factors underlying the mental disorder. Let us study them in detail.

*Heredity* : Among the biological factors heredity looms large and both psychiatrists and laymen turn to it for explanation of good many mental and physical disorders. Contemporary investigators too emphasize the importance of heredity in view of the widespread incidence of schizophrenia in families. Kraepelin studied 1,054 patients of schizophrenia and found that 53.8 per cent had a family history of mental disorder. Kallmann studied the family history of 1,000 schizophrenic patients and on the basis of his study deve-



developed a genetic theory of the dynamics of schizophrenia indicating an individual's average expectancy of becoming a schizophrenic. Ordinarily an average person has only one per cent chance of becoming a schizophrenic patient but if one of his parents suffered from this mental disorder his chances of getting this mental disease increase to 16 per cent. For siblings they are 12 per cent, for half-siblings they are eight per cent and for nephews they are four per cent. The percentage for grandchildren is the same as that for nephews. Where both parents are schizophrenics the percentage rises to 68. Thus the factor of heredity is powerful in predisposing individuals to this mental disease. Making a study of identical and fraternal twins, selected for schizophrenia symptoms he found that if one twin was schizophrenic the chances of the other twin being schizophrenic were 86 per cent.

The above data may be interpreted as deciding in favour of heredity but some writers have interpreted that in view of some people not getting it even though their parents had it the factors of environment cannot be ruled out, at least heredity alone is not the only predisposing factor. If heredity were the sole factor every twin would have got it and the fact that a good percentage are free from it argues in favour of environment.

*Constitution :* Ever since Kretschmer emphasized constitutional types in personality and associated mental disorder with physical constitution, investigators have sought in physical constitution an important factor determining mental disorder or psychotic disturbances. Kretschmer stressed that schizophrenic patients tend to be of asthenic or slender build and Sheldon in his study is inclined to confirm Kretschmer's conclusion. Later investigations tend to show that all varieties of body builds are found among schizophrenics but because schizophrenia attacks youthful patients the asthenic type is more common. Asthenic physique is inclined to hebephrenic schizophrenia and athletic type to paranoid type.

So far as their temperament is concerned schizophrenics tend to be quiet, sensitive, introspective, withdrawn from reality, self-sufficient, taciturn and reserved. They are introverts, shut-in personalities. Children who may later develop schizophrenia are inclined to be lonely timid and sensitive people who prefer day-dreaming to vigorous outdoor activity.

*Physical basis :* Attempts have been made from time to time to trace the origin of schizophrenia to disturbances of the endocrine system or of the brain functions but with little success. No broad-based conclusions have been drawn.

### *Physical symptoms of schizophrenia*

A great deal of study has been made of the physical symptoms of schizophrenia, that is of the nature and functions of the several physical organs of schizophrenic patients. Changes found in the endocrine glands, brain and other physical parts were not confirmed by others, as has been indicated above. Again some of the physical symptoms found in schizophrenic patients could have been caused by starvation, strain of over-excitement and inactivity which are very frequently found in such a mental disorder and not by the mental disease itself. Disturbed appetite, loss of weight, refusal to eat may also be due to such physical processes accompanying this disturbance. As has already been pointed out extremities, nose and ears become cold, clammy and bluish. Reactions of pupils may also be disturbed. Usually pupils dilate when there is pain but a schizophrenic does not respond to pain in this manner.

### *Psychological factors*

Great stress is laid on the role of biological factors in schizophrenia but this does not mean that psychological factors are absent. Almost all scholars have held that psychological factors of frustration and conflict are no less powerful. Bleuler in particular has emphasized that the splitting of personality in schizophrenia is mainly due to strong complexes. Because schizophrenic reactions include dulling of emotions or over-excitement some people believe that the life of a schizophrenic patient is devoid of all emotions. On the other hand it is more correct to say that his emotions are so strong, so painful and so violent that he has no other choice but to repress them. Then this repression is so intense that it affects all his emotional reactions with respect to himself and his environment. Sensing that the world is hostile and painful he withdraws from it altogether as has been seen in catatonic stupor. His silly giggling and laughter on the one hand



and his wailing and weeping on the other are both futile attempts to express his repressed emotions as well as to give them scant expression. He is afraid to have warm and affectionate feelings toward his fellowmen and, therefore, withdraws from them. He is also afraid to show any positive normal emotion.

Adolph Meyer held that schizophrenia must be viewed as a reaction type and the result of repeated failures to adjust to the environment. Therefore, before treating any patient it is better to study his life history and see if he has had failures in meeting the challenge of his situations and problems, whether instead of entering whole-heartedly into the arena of close competition of life he indulges in day-dreaming and phantasy. Meyer thinks that a potential schizophrenic's attitude is marked by evasiveness toward reality resulting in suspiciousness, fault-finding obstinacy and seclusiveness.

Carl Jung thinks this mental disorder is the result of repressed complexes, the libido is directed to childhood purposes, because it cannot move forward as a result of failures of adjustment it moves inward and backward, and it moves along infantile channels of earlier days.

McDougall believes that this mental disorder is the result of incongruity in social relations and in several dispositions which enter into the organization of the sentiment of self-regard. This sentiment has not developed harmoniously and when this disharmony reaches an abnormal extreme it results in schizophrenic reactions.

Strekker and Ebaugh argue that schizophrenia is the result of an introverted personality of the very extreme type, but it is difficult to accept that a schizophrenic is just that and nothing more considering the large variety of symptoms of which he gives evidence.

We may have, therefore, to guard against the tendency to oversimplifying the issue and stress just one cause. Earlier we have stressed the fact of multiple causation in mental disorders.

It must be remembered that schizophrenia is the most common of all psychoses, it is also the most difficult to understand, and every

care must be taken to identify its symptoms before regular treatment is attempted.

### *Sociological factors*

The rôle of sociological factors in the development of schizophrenia has not been duly stressed and very few studies have been made of this aspect, but the few that have been made stress the fact that there is more schizophrenia in our modern culture than it was in primitive cultures, and within our own culture it is more prevalent among poorer sections. It drives us to the inevitable conclusion that because there is greater disorganization of social life among poorer people and no satisfactory solutions of problems of social adjustment can be had, therefore, it is more prevalent. One investigator suggests that the increased stress and strain and lesser security of larger cities than in rural areas is an important sociological factor in the development of schizophrenia. It has been found to be more prevalent among nuns but there is another side to it. May be that those who are inclined to be schizophrenic and meditative go in for the life and work of nuns. In any case greater and closer study of the sociological factors in the dynamics of schizophrenia is called for.

### *Treatment of schizophrenia*

The best thing to do about schizophrenics is to admit them to a hospital. It is not possible to treat them at home. Hospital treatment has certainly tended to reduce the number of deaths due to certain infections like tuberculosis and pneumonia to which patients of schizophrenia were more prone because of weak physical condition. Good nursing and careful nourishment along with ready medical aid helped them. Ever since shock therapy was devised insulin treatment has been found to be very helpful, in fact more helpful than any other shock therapy. The percentage of recovery with insulin therapy has gone up to 50. In a follow-up study it was found that the percentage of full recovery was a little less. Some therapists have pleaded for combining insulin treatment with electro-shock therapy and in this combined treatment the percentage of recovery cases is larger.

In another study it has been stressed that the results of shock



therapy in the long range are less satisfactory and many cases tend to relapse after a period of time. Another investigator stresses that the combination of shock therapy with psychotherapy yields better results. Psychotherapy helps the patient to get insight into the nature of his trouble and to achieve better adjustment to his environment. Such aids as recreational therapy or occupational therapy also help as they give a happier contact with reality and provide outlets for emotional expression.

Other more radical forms of treatment are psychosurgery and frontal lobotomy but chronic cases have not responded satisfactorily to such treatment.

Group therapy has been quite helpful in providing the schizophrenic patients with a safe social environment for making social adjustments of very healthy type and effecting socialization of the patient, who had withdrawn from the world of things and persons. We have already described in the previous chapter the several techniques of treatment.

Sterilization of schizophrenic patients would cut down the number of patients in the next generation but such a reduction would be just four per cent. Only 10 per cent of schizophrenic patients are descended from schizophrenic parents. From the point of view of biology schizophrenia is self-limiting. Perhaps the best remedy would be to prevent parents with schizophrenic trends from marrying each other. They may not themselves be schizophrenic but may have schizophrenic trends and carry the mental disease to their progeny. If a reliable prognosis could be made such people should refrain from marrying those who have schizophrenic trends.

Prognosis for all types of schizophrenia is not the same. If the patient is treated early, if the onset of the disease is acute and sudden rather than slow and gradual, and if precipitating conditions like the death of a dear relative or financial loss is known it is possible to cut short the period of disorder. If at the same time the patient has a clear insight into the nature of his illness it is easier to forecast and treat the disorder. Favourable environmental conditions also help. These conditions are necessary and helpful for an effective treatment of the patient, the most important thing is that the illness should be detected early and

steps should be taken to prevent its attack. In that case it is necessary to know what are the important trends in personality which should be attended to early so that the germinal traits of personality are neutralized or reduced in intensity in time before they develop into a full-fledged mental disease. Such personality traits are lack of social feelings and attitudes and withdrawing from social life and contacts, seclusiveness and introverted attitudes, rigid personality and lack of flexibility in approach, narrow interest, emotional apathy, touch-me-not attitude towards comments and criticism, extreme shyness and self-consciousness. It is not being argued that such personality traits always pave the way for an attack of schizophrenia but their early detention and correction will certainly help to ward off the disorder. These traits can be easily checked and tested by some of the personality tests which have been described in some previous chapter.

### QUESTIONS

1. Discuss the nature and symptoms of schizophrenia.
2. What are the several types of schizophrenia? Briefly describe their distinguishing symptoms.
3. What are the general causes of the psychosis schizophrenia? Discuss how far it is inherited.
4. What steps should be taken to prevent or reduce the prevalence of schizophrenia?
5. What personality traits favour the onset of schizophrenia? How would you identify them and what steps would you take for their treatment and correction?
6. Describe the symptoms of simple schizophrenia, hebephrenic schizophrenia, catatonic schizophrenia and paranoid schizophrenia.
7. How would you proceed to treat a case of schizophrenia? Describe some of the effective techniques of treating this mental disease. What are the prospects of a patient of schizophrenia for recovery?



## The Functional Psychoses

*Manic-Depressive Psychoses*

Manic-depressive psychoses imply a variety of emotional disorders characterized by mania, depression, or, in some cases, alternation of the two. No physiological disturbance has been shown to cause this type of psychoses. Symptoms are either of over-excitement or of over-depression but there is also a mixed variety in which these two types of symptoms alternate. The major symptoms of the manic phase are prolonged elation, over-talkativeness, excessive motor activity, seemingly without any reasonable cause. The patient throws prudence overboard with regard to his own safety and with regard to that of others, and to lose his social inhibitions. His whole behaviour is that of a strongly intoxicated person except that it is continued over a much longer period of time.

The depressive patient presents just the opposite symptoms. He has prolonged depression without any reasonable cause. He is not able to do much and feels "rotten". He does not talk much and is weak. There is a poverty of ideas and psychomotor activity is at a very low level. Mixed states include alternation of these phases of the emotional disorder. At one time the patient is over-excited and at another he is depressed. Some patients show only manic reactions, others show only depressive reactions, still others show both types of reactions alternately or together. We may discuss them separately one by one.

*Manic reactions:* Manic patients are forever active and moving. They cannot relax and sit still. They are forever in a fever of excitement and activity. Every passing thought is acted out. A large number of things must be done together and immediately. A person suffering from manic reactions flits madly from one task to another. He is always on the go, always busy. His activities are not aimless but have a purpose, only there are too many purposes to be accomplished in too short a time. Hyper-

activity or "pressure of activity" is his key symptom. This is also accompanied by "pressure of speech" and he goes on talking. He is over-talkative and gay. Some very dull people also become gay and entertaining and show a mastery of language which they would not show in their normal capacity.

The patient is elated, happy and gay. He has a general feeling of well-being. He thinks very highly of himself and is very hopeful and cheerful. He believes that everything will turn out nicely for him. He may cut jokes and laugh at people around. He succeeds in punning and is very enjoyable company. Such a state of joy and well-being is called euphoria. He is not tactful but inclined to be carefree, jolly and boisterous. He is full of liveliness and energy. Because he lacks restraint and social inhibitions he has no hesitation in using obscene expressions. If he is obstructed he becomes violent, ready to attack, arrogant and very quarrelsome. As has been pointed out above a manic patient acts and looks like an intoxicated person.

Another symptom is extreme flight of ideas. Thoughts crowd in on him and trying to answer any question he is so overwhelmed by passing thoughts and reactions to external stimuli that his answer is confused. His thoughts become disconnected and jumbled. He seldom completes his sentences. There may be too much repetition in his speech and for too many associations his thoughts may drift in several directions at the same time. As there is a rapid rush of ideas so there is a rapid flow of speech. There is utter lack of concentration in thought or speech, and ideas may follow any chance suggestion from the people around.

Other symptoms are extreme suspiciousness of the actions and motives of others with delusions of persecution at their hands or of sexual overtures, extreme irritability when criticized or thwarted, delusions of over-valuations, grandeur, wealth, power or divine mission. These delusions are of short duration and are changeable. Some authors include hallucinations too but they are mostly faults of perception which are wrongly interpreted.

Because of hyper-activity and elation there is loss of appetite and under-nourishment. Even in normal people over-excitement leads to errors of judgment and in a maniac errors of judgment



are common. They may accept that they are over-active but will not admit that they are ill or mad. Rather they will argue that the nurses and doctors are mad.

*Degrees of mania* : There are three stages or levels of mania depending on the degree of intensity of excitement and elation, and they are *hypomania*, *acute mania* and *hyper-acute mania*.

*Hypomania* : This is the mildest form of manic reactions and is marked by moderate elation, flightiness and over-activity. The person has a feeling of well-being and sees the bright side of everything. His mood is that of elation and optimism. He reacts to everything with joy, he is immensely pleased with himself and is ready to join any game of life. He is like a mildly intoxicated person. He is full of vigour and enthusiasm. He is eager to bring about changes in this world and talks and writes profusely. His attitude is one of exaltation in which he is very much pleased with the world. He is irritated only when he is thwarted or criticized. He speaks rapidly and loudly and it is not possible to dispel his mood of self-sufficiency.

He may give the impression of being brilliant and sociable, with commendable plans and enthusiasms. But his plans are seldom worked out. He has poor judgment and insight into his trouble. He will abuse people who tell him that he is mad and should be sent to a hospital.

*Acute mania* : The symptoms described above are more pronounced in acute mania. This condition may develop out of hypomania or may come on all of a sudden in which case it is generally preceded by a period of insomnia, irritability and restlessness. He may talk much more loudly, may be boisterous and very gay. He becomes very overbearing and boastful. He not only talks very rapidly but it is not possible to understand him so incoherent he is in his speech. His motor reactions are more rapid and his facial expression is more changeable, his eyes bulge and his movements are more violent. When crossed he is much more irritable and destructive. He may bang on the wall and doors demanding his release, he may sing and walk up and down. He may have delusions and hallucinations but only for a very short time. Judgment and insight are severely impaired. Now and then

there may be moments of calmness when he may express regret for his doings, but these are very short and he soon relapses into his manic state. He may amuse the people around him.

*Hyper-acute or delirious mania* : This is the most serious state of mania in which the patient reaches a state of delirium. He is very much confused, wildly excited and greatly violent. He aptly comes up to the level of a real mad man. His speech is very incoherent and his personality is entirely disorganized. He has no understanding of his environment and may have wild delusions and hallucinations. Most of his activity consists of wild shouting, screaming and singing or pacing restlessly. His face may be distorted and he has a peculiar glare in his eyes. He is in perfect frenzy and may break things, rave or cry. He has to be restrained lest he should drop in sheer exhaustion, because his activity is unceasing and does not let him have any rest or sleep. As very heavy burden is placed on all his bodily functions he loses weight and the chance of infection by various diseases is very great.

*Depressive reactions* : Here the symptoms are just the opposite of what is found in manic reactions. Let us study them in detail.

The major symptoms are loss of enthusiasm and a general retardation of physical and mental activity. The patient feels discouraged and dejected, he loses all initiative and energy and is not inclined to undertake anything. It is difficult for him to take a decision and more so to execute it. Even very small jobs appear heavy and tremendous. He has no inclination to be up and doing. He prefers to lie in bed and may not feel equal to the effort of getting up. If he is somehow persuaded to get up and dress, he tires very soon. The zest of living is lost and he is in the grip of extreme inactivity. He would like to lie in a corner all alone and utterly inactive, often in the same position. When the condition worsens he lies motionless in bed.

Mental activity is very much retarded and most of the patients complain that they can neither concentrate their attention nor collect their thoughts. Memory also fails them and they are unable to recall. They feel that their mind is blank. They are unable to plan any course of action or to carry on conversation though they may answer questions correctly. They do not make



any remarks themselves. They run out of thoughts or words and some of them do not speak at all. They may give an impression of mental dullness but there is no intellectual disturbance.

They have no hope, no zest, no interest. For them life is one long period of brooding and gloom. Their psychological drives are weak and low and their motives, if they have any, cannot be known. They may accuse themselves of all sorts of misdoings and be fearful of their consequences for themselves and for those around them. They are always regretting what they did in the past and they have no hope of the future. Emotionally they are inert, they do not respond to any social stimulation, and they have suicidal trends though with their dullness it would be too much to expect them to take the trouble of committing suicide. Jokes do not make them smile nor their gloom or grief bring any tears. They are irritable, apprehensive and self-reproaching. They have feelings of guilt and of their unworthiness. They may have delusions that they are suffering from all sorts of diseases and worry a great deal about their digestive disturbances. Insomnia, loss of specific appetite and lack of proper adjustment to their surroundings are common.

Patients with depressive reactions do understand that they are ill and need treatment, but their understanding is coloured by feelings of despair and gloom. They have great fear of losing their mind and becoming insane.

Like the manic reactions depressive reactions also have degrees or levels of the intensity of their symptoms. There is *mild depression* or *simple retardation* in which thinking and acting is slower than that of a normal person. The patient no longer smiles and wears a sad expression. His looks undergo change, self-assurance, joy and calmness are gone. Instead he has faltering, hesitating manner, his approach is slow and indifferent, his writing is slow and his mental functions are retarded. He has feelings of guilt, unworthiness and self-condemnation. He prefers to sit alone, think of his sins and lose all hope for the future. Most of these patients know that they are ill but believe that they do not need any treatment or that no treatment will do them any good. Instead they complain of headache, loss of appetite and sleep and fatigue.

They think that these troubles are punishments for their past sins and offences.

In *acute depression* these symptoms are aggravated, mental retardation increases, inactivity and seclusiveness grow worse and the patient does not speak of his own accord. Feelings of guilt and **self-accusation** grow stronger and he holds himself responsible for many social disasters like plague or floods. Delusions that he is suffering from all sorts of diseases are common and he may believe that his brain and intestines are being eaten away or wasted. He may refuse to eat saying that he has no stomach. He has no hope of his recovery and ideas of suicide are not uncommon.

The third grave stage is that of *depressive stupor* in which the patient lies in a state of stupor and is completely inactive and unresponsive. He mostly lies in bed and is completely indifferent to what goes on around him. He refuses to speak or eat and may have to be given artificial feeding. He is extremely immobile. He is generally constipated, has foul breath and badly impaired general health. Even when he has calmer moments it is not possible to know from him the nature of his trouble. He has delusions and hallucinations about sin, death and rebirth.

*Incidence* : About 5 out of every 1,000 individuals may be expected to suffer from this mental disease. Of patients admitted to mental hospitals 10 to 15 per cent are manic-depressive. Attacks may occur at any age from puberty to old age. The average age of admissions to mental hospitals is about forty years. Women suffer from this disease at any age earlier than that for men. It is more prevalent among women.

### *Predisposing causes of manic-depressive psychosis*

Let us consider what biological, psychological and sociological factors predispose a person to manic-depressive psychosis.

When biological factors are considered heredity, constitution and organic pathology get mixed up. From the studies of hereditary basis of this psychosis it is quite clear that heredity plays an important role. The prevalence of this psychosis among the relatives of manic-depressive patients is considerably higher. But generally all arguments in favour of heredity are obscured by



the influence of environment, for after all it is difficult to determine what an individual owes to heredity and what he owes to early environment. In a home inhabited by manic-depressive patients the predisposition for manic-depressive reactions is stronger. But still the high percentage of patients of this psychosis among close relatives tilts the argument in favour of heredity.

The investigations conducted by Rosanoff show that 30 per cent of identical twins of manic-depressive patients are free from this disease. This means that hereditary factors are not the sole cause and environments cannot be ignored. But it is difficult to say what these environmental factors are. Some of the factors which must be considered are serious illness, childbirth, financial losses, loss of employment, death in the family and disappointment in love. These factors may be present together or alone. It may be observed, however, that these by themselves do not cause manic-depressive reactions but they act as precipitating factors.

Physical ailments like headache, lack of sleep, indigestion and the like may also precipitate this psychosis. In fact such symptoms are common in the milder form and in the initial stages. It is a common experience even with normal people that the presence of these symptoms discourages and dejects an individual and if a person is highly emotional the effects of such symptoms are likely to be highly exaggerated.

Kretschmer believed that manic-depressive patients are of the pyknic type, that is, they are stocky, thick-set, short and vigorous individuals. In Sheldon's scheme the mesomorphic, that is, the athletic, muscular, solid, energetic, aggressive type, and the endomorphic, that is, the stout, plump, sentimental, pleasure-seeking, extroverted type, are prone to the development of manic-depressive reactions when placed under great stress and strain. Now the question arises whether such personality traits lead to the development of certain types of physique or the other way about. Perhaps there is some sort of interaction between the two.

According to Kraepelin this disorder is due to some toxic effects but later investigators are of the opinion that no organic defect can be associated with this disorder. The physical ailments listed above are not really causal factors but are likely to be

interactional in function. Nor has any organic defect been discovered in brain.

Psychological factors indicated above are of great importance. From the cases studied it is clear that high moral tone in the family in early childhood together with over-strict discipline are common. Later stressful experiences precipitate the psychosis. It is such life experiences which also determine the mental disease and functioning.

Manic-depressive patients are evenly distributed over various sections of people from educational, occupational and socio-economic point of view. From this some authors argue that it is the factor of heredity which is most important but it may equally be true that there are some selective factors working in this disorder. However, sociological factors in manic-depressive reactions still remain to be clarified.

*Treatment* : The manic-depressive patients should be lodged in a hospital where they get not only physical care but also disturbing influences and minor irritations common in the home are removed. The patients are also protected from any possibility of suicide and dangerous behaviour.

In a manic case the immediate need is to reduce over-activity and this may be partially accomplished by removing stimulating factors from the environment. Another urgent thing is that the patient's confidence should be gained and all restraints and unnecessary irritations should be avoided. If nursing is careful the patient can be directed to engage in some constructive activity. In a milder case the patient may be asked to record his memoirs or write his autobiography. If he is not too much excited psychotherapy will help, and giving him opportunities for recreation and useful occupation will prove useful. To calm him down physiotherapy like hot baths and massage will benefit. These may be accompanied by prolonged narcosis, electro-shock therapy and metrazol convulsive therapy. The over-activity and over-excitement is generally short-lived but the treatments suggested do not really shorten the cycle of manic reactions.

In depressive reactions an important thing to do, to begin with, is to reassure the patient that his recovery is not only



possible but certain and that he should not lose hope. A little of self-assurance and optimism on the part of the patient will help considerably. What symptoms there are should be relieved by sedatives. Electro-shock treatment is of immense benefit in depressive reactions. After a series of electro-shock treatment a good many depressive patients become animated and lively and begin to have a normal attitude to life. At this point psychotherapy is of great benefit so that what improvements have been effected should be maintained and better personality adjustments are achieved.

But in manic-depressive reactions time is an important factor. Long hours of sleep with the help of drugs is helpful and the patient may sleep out his reactions if sleep is carefully regulated. Many manic patients exhaust themselves by over-excitement and over-activity and careful medical treatment is necessary so that they do not suffer from the ill-effects of any other disease. Insulin therapy is of no use at all.

Many patients recover even if they are given just hospital care and no psychiatry. Frequently the duration of the disease is just six months or so, and more than 60 per cent patients are discharged from hospitals after five years as cured. Electro-shock therapy and metrazol convulsive therapy have increased the rate of recovery. When the patient recovers he is his normal self and there are no personality defects whatsoever. His personal, social and occupational relations and efficiency do not suffer in any case. Generally attacks which occur early in adult life or which come on all of a sudden have a greater chance of recovery than those occurring late in life or which come on gradually.

Does this psychotic trouble recur? If so how many people have recurring attacks? On the basis of admission to hospitals in the United States it may be safely claimed that 60 per cent admissions are first admissions and the other 40 per cent are those who after enjoying a period of good mental health had the trouble again so much so that admission to the hospital was necessary. This should dispel the widespread impression that manic-depressive reactions are a recurring disease. In fact most manic-depressive patients have only one attack in their lifetime. Those patients

who have recurring attacks generally develop symptoms of the mixed type in which mania and depression occur alternately.

### *Involucional Melancholia*

This psychosis is closely allied to the manic-depressive reactions, particularly what is called "agitated depression" or the "mixed type" of manic-depressive reactions. It is marked by severe depressive reactions particularly in the later part of life in people who have never had a psychotic episode. Involucional melancholia is distinguished by its initial occurrence in later life during the general involutional period of bodily and mental decline, by its tendency to long duration and by the failure of patients to make spontaneous recovery. The involutional period of life ranges from 40 to 55 years in women and from 50 to 65 in men. Its typical symptoms are paucity of thought. The average age of patients admitted to hospitals for this psychosis is 54 for women and 55 for men. Most of them are between 40 and 65 years of age. It is more prevalent amongst women than men. Only four per cent of total admissions to mental hospitals suffer from this psychosis, two per cent of male and seven per cent of female. Thus involutional melancholia is three times more prevalent among women than men.

This disease comes on very gradually and is generally aggravated by some sudden tragedy in the family, loss of employment, death of some close relative, financial losses.

The major symptoms are as follows :

There is great depression accompanied by agitation and anxiety, but there is no mental retardation. But although patients are not slow or retarded in thinking or making responses it is difficult to hold any conversation with them. They are highly depressed and feel unworthy or worthless. They indulge in great self-devaluation and believe that they are no good. They appear to be in great misery and anxiety that something fearful is going to happen to them. Apprehensiveness is very acute. No doubt similar thoughts are found among normal people also when they are depressed and assailed by anxiety. Depression and agitation are present together, though the patient does not say anything



and keeps wringing his hands. Often he is preoccupied with some real or imagined misdeed and feels that he will never be forgiven and is eternally condemned for some unpardonable sin. Often the patients seriously try to recall some past misdemeanour or indiscretion, magnify it several times and make themselves miserable. They do not hope for any forgiveness. They may imagine themselves falling into extreme poverty or that some other disaster may befall them. They may beg for mercy or they may beg to be punished or tortured. They may even refuse food or other good things protesting that they do not deserve them. They must be carefully looked after lest they should try to commit suicide or do some harm to themselves.

The patient has strong feeling that nothing around him is real and that he himself is unreal. He does identify things and persons around him but he feels some strange distance between himself and them. Nihilistic delusions are present. They would say that nothing is real, everything has changed, they themselves are changing and life has lost all meaning. They may say that their brain, stomach or tongue is gone, that they are drying up, that they are suffering from some incurable serious disease, that their relatives are dead.

The physical symptoms during the period of depression are about the same as appear in manic-depressive reactions, that is, lack of appetite, sleep and rest, headache, indigestion. But in addition there are symptoms of old age, menopause and the like.

The feeling of unworthiness is generally accompanied by extreme suspiciousness, delusions of sin, guilt and persecution.

To sum up : involuntional melancholia is marked by agitation and depression marked by a feeling of unworthiness and inadequacy based on the decline of bodily and mental functions. Thus a woman may feel depressed that she has lost her looks and is helpless, and about to be rejected. Or a man may feel that he is no longer able to earn and contribute to the family funds.

*Interpretation :* There is no doubt that with the decline of life physical and mental functions degenerate. The endocrine glands undergo radical changes. Some writers hold that this psychosis of involuntional melancholia is due to changes in the endocrine system,

Others maintain that it is the result of physical and mental decline associated with the age of the patient. In this direction some experiments have been made. If the psychotic trouble is due to endocrine deficiency then injections of endocrine hormones or drugs of hormone composition should prove effective in curing it but it is not so. Besides why should it happen only in the lives of some people and not all people who grow old.

Psychologists are generally of the view that this psychosis is aggravated by certain psychological stresses but some trends and traits favouring it already exist in the personality of the patient. Most of the patients who suffer from it have been found to be shy, stubborn, methodical, frugal, unduly conscientious and inhibited. They are serious people whose lives are regulated by a high sense of duty and strict moral principles. They have not wasted time in recreation and have worried about one thing or another all the time. So long as they were strong enough to bear the strain of worry and anxiety they stood the strain and made suitable adjustments to life as well. But when their mental and bodily functions weakened they went under. With growing old age their disappointments and failures, their fears and worries weigh down on them and bring on the psychotic trouble. They feel insecure, afraid of retiring from work, of facing poverty, and the external world no longer holds any interest for them. The world, therefore, seems unreal and meaningless, and they turn inward, turn over their past life, their present bodily weaknesses, and often think about death.

*Treatment* : There is danger that such patients may commit suicide and, therefore, it is very necessary that they should be removed to a mental hospital and kept under supervision. They should be given nourishing diet, relaxation and interesting constructive work so that they are encouraged to take a hopeful view of life. Psychotherapy is of little help so long as the symptoms are acute, in milder cases it should be tried. Aging is a universal process and those who understand its inevitability and accept its handicaps are the better for it. In India good many old people engage themselves in social service of one kind or the other and it gives them opportunities for creative endeavour.

Involitional melancholia is generally of long duration and



patients do not recover of themselves without regular treatment. Electro-shock therapy has been found very useful in involutional melancholia, particularly where the duration of the illness has not been very long, not more than one or two years. Other aspects of treatment are those which have been described in the case of manic-depressive reactions.

### *Paranoia and paranoid conditions*

The term *paranoia* is very old and was used even by Greeks and Romans, but its use was indiscriminate, and it is only in our own age that its limited use is made to denote systematic delusions without any deterioration of personality. These delusions are stable and systematized so that if the hypothesis of the patient being persecuted or being some grand personality is accepted the rest of the delusion follows logically. These delusions are unshakable and the patient stubbornly defends them. When these delusions are discussed the patient becomes quite lively. His thinking and behaviour is quite coherent. There are no disturbances of memory and hallucinations are absent. Most of the patients of paranoia are self-supporting and of high intelligence. They do not need any prolonged treatment or supervision in a mental hospital. As long as they do not talk about their delusions they look normal and also work quite normally except that they look a little strange.

Paranoid disorders have generally two types of paranoid reactions :

1. Paranoia marked by slowly developing delusions which are very well systematized, logical and complex centres round delusions of persecution or/and grandeur. There is no personality deterioration and the patient's behaviour and thinking are not impaired.

2. Paranoid condition, with transitory paranoid delusions, does not have the system and coherence in its delusions. This lies in between paranoia and paranoid form of schizophrenia. Its delusions change and are less logical. Thinking is a little disconnected, and there are hallucinations too, but their emotional and intellectual behaviour is intact. Patients of paranoid condition are usually able to manage their own affairs but now and then they may become dangerous when they have strong delusions of persecution.

On the basis of types of delusions paranoia patients are classified into four groups ; or rather there are four types of delusions :

*Delusions of persecution* : This is the most important symptom in a large majority of the cases of paranoia. The content of the delusion may vary but the pattern is the same. The patient is fully convinced that someone is going to harm him, thwart him and induce others to do it, or that there is some secret conspiracy for doing malicious propaganda against him among his friends and employers. He may try to defend himself by asking his persecutors to leave him alone or he may write letters to newspapers to vindicate himself. He may seek the help of the police. In despair he may attack others in the delusion that they are persecuting him or may turn to commit suicide. He makes vigorous attempts to convince his family about the reality of his delusions and those who are suggestible and submissive are easily influenced.

*Delusions of grandeur* : After a period of delusions of persecution a paranoid patient may have delusions of his own grandeur or he may have ideas of his eminence at the very outset of the attack. Some authors like Bleuler hold that delusions of persecution and grandeur go together and they are very emphatic about this fact. There is no delusion of persecution without ideas of greatness or at least aspiration to greatness. Such delusions of grandeur compensate for failures and disappointments with regard to ambitions of youthful days. Some of them are inventors who think that others have made use of their remarkable inventions. Some believe that some eminent person is in love with them. Some have delusions about their noble birth. And some believe that they were born with a special mission and are prophets or leaders of some great religious movement or political and social reform. Some of them do succeed in winning a large following.

*Delusions of jealousy* : Married or betrothed patients of this psychosis usually have delusions that their husbands/wives or fiancées are not faithful. They may even hire detectives to find out about them. If a husband just smiles at another woman or a wife has intimate conversation with another man, he or she is suspected of infidelity. Some of them may be feeling free of all marital responsibility by accusing their partners of lack of faith.



*Delusions of litigation* : These are of comparatively rare occurrence. In such delusions patients are continually engaged in litigation, defending injuries or their rights and seeking justice. They are so persistent that they annoy their friends and waste their money.

*Incidence* : Such parancid reformers, prophets, inventors and the like are found in every community. Not long ago an aged person was found in the streets of a metropolitan town with a banner in his hand and a number of booklets in his case shouting that he could prove that the earth is flat. He wanted to be invited to educational institutions and assemblies of experts and railed that geography books are all wrong. Some, however, make a nuisance of themselves in public and have to be removed to hospitals. Such patients count for two per cent of the total admissions to mental hospitals and the percentage for men and women is the same. The average age of admitted patients is about fifty years and some symptoms are reflected early in life. Most of them are highly intelligent people and come from the cultured class.

*Interpretation* : In paranoia and paranoid conditions, as in all other functional psychoses, the patient must be studied in his entire case history to find out what predisposing factors and traits were predominant in his life and also what stresses and strains have precipitated the onset of this mental disorder. The psychotic condition is always a continuation of some psychotic trends and traits in the personality of the patient. Before having delusions he was a suspicious, irritable, conceited and morbidly sensitive person, without any sense of humour and taking everything very seriously including himself. He is extremely self-centred, distrusting everybody, having highly exaggerated ideas about himself. Let us discuss dynamics of such patients in detail.

Biologically no hereditary factors in the incidence of paranoia and paranoid conditions have been noticed. Kretschmer held that paranoids were constitutionally asthenic but later studies show that they are found in all bodily and constitutional types. There is no evidence of any organic defect, tumours or endocrine degeneration. No biological factors, therefore, have been identified as causal in this psychosis.

The psychological factors seem to be all important and some

of them have their origin in the experiences of early childhood, some in the development process of the individual. As children most of the paranoid patients seem to be sullen and morose, aloof, suspicious, stubborn and resentful of discipline. Good social adjustments with their playmates and participation in cooperative activity is absent from their experience of early days. Some of them lost their parents in early childhood, while others received too much pampering from their parents. A good many of them were "spoiled" children.

Later they grew into arrogant, self-centred and rigid personalities who would like to dominate and who are just touch-me-nots, taking insult at every turn. Their goals and expectations are always too high and they brook no half measures. They are normal and have broad interests but they are unable to establish close and intimate relations with other people. They are over-conscientious, hyper-sensitive to criticism and over-enthusiastic in doing very trivial things.

Such proud, self-centred and rigid personalities are bound to meet with failure in the accomplishment of their goals. Any failure will disturb them badly and breed feelings of inferiority and even guilt. When their sense of adequacy is undermined and their self-esteem is injured by the expected or imagined scorn and ridicule of others, they are most likely to project the blame for their failure on others. They failed not because they were incompetent but because others failed them, worked against them or were trying to do them some harm. With this defence mechanism they begin to falsify reality. Projection is the most striking and consistent aspect of the paranoid reactions. Reality and the world around is interpreted in the light of their subjective thoughts and feelings. In their normal intellectual activity they bring in logic to support and sustain the distorted versions of the reality and the world. However, this distortion is limited to one theme and the rest of the personality does not suffer. In the words of Freud a paranoia patient will say, "I don't love him, I hate him ; I don't hate him, he hates me."

Their self-condemnation and feelings of worthlessness are the result of sexual maladjustments. Most of them followed a very rigid code in relation to sexual behaviour and tried to force this code on



others. Homosexual conflicts too have been found in paranoia. Their sex development is not mature.

Some writers stress that feelings of guilt in a paranoid patient result from high ambitions and goals and very poor achievement. He sets very high standards but being unable to achieve them he blames others. Being himself unfaithful he charges his spouse for infidelity. If he is not faithful he may have wanted to be and may thus justify himself by projecting his infidelity or the desire for it on his wife.

As has been pointed out patients of paranoia are highly intelligent and come from a cultured stratum of society. But how far this fact is responsible for this psychosis is not clear. May be that this section of society has too high goals which individuals are unable to reach.

*Treatment :* Some believe that paranoia and paranoid conditions are incurable, but others believe that much can be done to help the patient. In the early stages of paranoia psychotherapy or a combination of psychotherapy and electro-shock treatment may be effective. Careful interview treatment may prove helpful in dispelling delusions and giving the patient an insight into his illness in the course of a few months. In a more advanced case the patient should be admitted into a mental hospital where it is most essential that the doctor should establish a close and intimate relation with him so that he can make him understand the nature of his reactions and convince him that his delusions are not well-founded. It is true that symptoms of delusions are fixed and resist change. Some writers believe that it is useless to try to change such patients and all that can and should be done is to make them understand that if they continue to behave like that they will be sent to jail or punished. These patients consider themselves superior to psychiatrists and refuse to co-operate with the staff in the hospital. They try to escape from the hospital by trying to show that they are cured. Others hold that sheltered environment of the hospital together with occupational and relaxation therapy goes a long way to help. But it must be understood that paranoia patients are seldom completely cured though such therapies have a sobering effect on the patient.

Paranoid states are usually short-lived and their chances of cure are generally more favourable.

## QUESTIONS

1. Describe the symptoms of manic-depressive reactions. What are the important factors responsible for them? How can they be best treated?
2. What are the several types of manic and depressive reactions? What are their chances of cure? Discuss.
3. What do you understand by involutional melancholia? Describe some of the major symptoms.
4. Discuss the several views regarding the origin and development of involutional melancholia. Can this psychosis be cured? If so, how?
5. What are the symptoms of a paranoid? Discuss the psychological factors leading to its development.
6. What are paranoid states? Can they be cured?



## Organic and Toxic Psychoses

A number of illnesses and other organic conditions affect the central nervous system and give rise to disturbances in mind and behaviour. There may be simple decline in mental and motor functioning and this may be accompanied by neurotic and psychotic reactions. Such reactions may depend on the nature and extent of the injury to the nervous system and the brain and on personality traits with regard to stresses and strains of life situations. How severe the mental disorder is will depend on the immaturity and instability of the mental and emotional make-up. On the other hand a balanced personality may be able to stand the strain of such stresses and brain damage. The severity of the brain damage is also an important factor.

Mental disturbances may appear in connection with brain infections because bacteria or viruses have entered the brain and destroyed the nerve tissues. We will describe some types of psychoses associated with infectious diseases, such as *general paresis*, *juvenile paresis*, *cerebral syphilis*, *epidemic encephalitis* and *epidemic cerebrospinal meningitis*.

*General paresis*

General paresis is caused by syphilitic damage to the brain tissue. The spirochetes of syphilis progressively enter the brain tissue and destroy it. This psychosis has also been known as *general paralysis of the insane dementia paralytica* and *paresis*. Only about five per cent of the untreated patients of syphilis develop general paresis. It may appear 5 to 20 years after the infection, and if it is not treated, it may lead to death within a year or so of the appearance of the symptoms. When the virus enters the body it spreads rapidly. The first symptom is a small painless ulcer at the site of inoculation within three weeks of the infection. A month or two later eruptions appear generally all over the body, and then skin lesions appear. These heal soon and the disease passes into a latent period of several years. If the patient is

not treated, the disease enters the tertiary stage marked by the destruction of various organs of the body. When this syphilitic destruction enters the brain psychotic symptoms appear.

There are several tests like the Wasserman, Kahn and colloidal gold tests by which liquid taken out of the lower part of the spinal cord is tested for determining the syphilitic infection.

Why only five per cent of the patients of syphilis should develop general paresis cannot be known.

*Symptoms* : General paresis has a wide range of physical and psychological symptoms. The physical symptoms are obvious enough. The pupils of the eyes do not react to light. The face has a peculiar appearance, the expression is vacant and the patient looks somewhat dissipated. There is a marked tremor in speech, both lips and tongue are affected, some words are slurred and there is some stuttering too. A phrase which gives trouble in most of the cases is "Methodist Episcopal", another is "Third Irish Artillery Brigade". The handwriting is not even, words and lines show signs of tremor and some letters are omitted or duplicated. In more serious cases it is difficult to read the writing. The patient walks in an unsteady manner and his movements are clumsy. In some cases the optic nerve is destroyed. In normal eyes it looks yellow but in severe paresis it looks white due to atrophy. There may be an absence of knee jerk.

The earliest symptoms are headache, dizziness and fatigue. To begin with the patient overlooks the social amenities, does not care about his appearance and habits, neglects his work and has no sense of responsibility towards his friends or family. In his conduct he has no moral standard, his judgment and memory are defective. He is very unreasonable in his emotions and there are many outbursts without any reason. He is irritable and at times over-sentimental. He is not aware of his trouble—that his personality is disintegrating. In the early stage he may have had some insight into his illness when his memory failed him or his efficiency diminished. As the disease progresses other symptoms appear such as dementia, that is, the decline of patient's intellectual faculties, depression, anxiety, delusions about his body that his heart or bowels are being removed or that they are dead, stupor.



Some patients become expansive and feel very happy and healthy, they boast of their greatness, power and vigour, of hundred wives and thousands of children. Later such ideas disappear and they grow agitated, restless and busy in some activity or the other all the time. Grandiose, persecutory and self-condemnatory delusions are common and occasionally hallucinations have also been noted.

*Treatment* : The treatment of general paresis can be conducted by medical specialists only. It can be prevented by adequate treatment in the first and second stages of infection. This should be done very promptly. Any delay means less favourable treatment. Once the infection has reached the brain and started destroying its tissues any treatment can only check further damage and the mental functioning is possible only within the damage done to the brain.

One technique of treatment is to induce artificial fever in the patient. Two methods are used to induce fever : infection with malaria and short-wave apparatus. In malaria method blood obtained from a malaria patient is injected either subcutaneously or directly into the blood stream of the patient of paresis. After a period of time the patient begins to have chills and fever ; his temperature rises to about 104 degrees fahrenheit. After about twelve such attacks the patient is given quinine sulphate to end the attacks. In some cases the improvement is fairly rapid but in some cases it is slow. A second course of malaria treatment is given after about a year.

Fever can also be induced by short-wave apparatus. The patient's temperature is raised to 104 degrees and kept at that level for six hours. Diathermy is also used and the patient is placed in an electrically heated cabinet. Vapotherapy which involves the circulation of air highly saturated with warm water is also used.

Fever therapy usually succeeds in checking further damage and helps to prolong the life of the patient. Studies made in mental hospitals indicate that partial or complete recoveries have increased by 45 per cent after the introduction of fever-therapy.

Another technique of treatment involves the use of arsenic. A compound of arsenic called tryparaamide is injected into the blood

stream once a week for eight weeks. After an interval of rest the injections are resumed.

There was a great deal of enthusiasm about penicillin treatment but the results are not as encouraging. It is injected daily for two or three weeks and a total of nine million units is injected. But authorities are not agreed as to its effectiveness. Some prefer it to other methods of treatment as it does not involve any complications but others would still use fever therapy.

Statistical studies show that the first two methods are still very successful. About 35 per cent patients are completely cured of their symptoms and they are able to live their normal life. Another 30 per cent improve but are unable to resume their old life. About 15 per cent show no improvement and 10 per cent die. The objective of all methods of treatment is to kill spirochete.

### *Juvenile paresis*

Juvenile paresis occurs in childhood or adolescence and is the result of inherited syphilis. It is a kind of general paresis occurring among young people. The infection is received from the mother before or during birth. Or a child may acquire syphilis by coming in contact with a patient suffering from this disease.

These children develop a juvenile form of paresis. The symptoms begin to appear between the ages of ten and sixteen, and both sexes are equally affected.

The symptoms are the same as have been described in the case of general paresis. There is a general physical and mental deterioration. Memory, judgment and understanding are affected. The patient may be expansive or depressed, there may be outbursts of violent emotion, movement and speech may be disturbed and there may be convulsions. The individual may take to stealing or fighting or both.

It is not understood why all children with a syphilitic taint do not develop juvenile paresis.

*Treatment* : The methods of treatment are generally the same as for general paresis but the chances of recovery are very poor. Juvenile paresis is seldom affected by fever therapy or chemo-



therapy. The best thing still to do is to start the treatment as early as possible. The preventive aspect of juvenile paresis is of the utmost importance. All states should make laws that every person should undergo a detailed physical examination before marriage and if the infection takes place after marriage there is always the possibility of preventing the fetus from infection by proper medical treatment. Syphilis accounts for more than 50 per cent of the born blind, it is also the largest reason for still births or of infant mortality.

### *Cerebral syphilis*

Cerebral syphilis differs from the general paresis in this that the damage is centred in the brain rather than the neural tissues. Nearly one per cent of the new admissions to mental hospitals are reported to be suffering from cerebral syphilis.

Its symptoms can be distinguished from those of the general paresis in their early onset. There is no marked deterioration in conduct, there is headache, dizziness, blurring of vision and often sleeplessness and nausea. The patient has difficulty in concentrating attention, pupils have difficulty in reacting to light. Wasserman and Kahn tests give positive reactions with blood but not with spinal fluid.

In the initial stage the damage done to the brain is less than that done in general paresis but damage to the brain is permanent. Most of the patients are not detected early and the hope for recovery is not favourable.

### *Epidemic encephalitis*

It is an inflammation of the brain tissue which has a tendency to strike the brain stem. Its virus causes widespread degenerative changes accompanied by a variety of personality disorders. When the disease becomes acute the patient is extremely lethargic and appears to be sleeping all the time. For this reason the condition is frequently called the sleeping sickness or *encephalitis lethargica*. This disease appeared in the epidemic form throughout Europe and America during the latter part of the First World War. Its symptoms have been noted in an attack of measles, mumps and other inflammatory complaints of the brain.

Its symptoms may take many forms but usually there is fever, drowsiness or stupor, the reactions of pupils are disturbed and the vision is not clear. The patient sleeps continuously though he can be awakened to take food or answer questions. He may sleep for many days.

Sometimes the sleepy state is followed by a state of restlessness, excitement, jerky movements and convulsions. After the acute stage patients become over-talkative and over-active. They may sleep during the day and keep awake at night. A common after-effect of this disease in adults is what is called *Parkinson's disease* in which muscles become rigid, speech is monotonous and the body is bent forward. The arms do not swing in walking and the gait is awkward. In children serious personality changes take place. Those who were well-behaved before now become mean, cruel, impudent and unmanageable. They are restless and have outbursts of violent emotion. They cannot fix their attention on anything for long and have little self-control. They indulge in all kinds of destructive behaviour and have to be lodged in a hospital or institution meant for the purpose.

Intelligence is also retarded. If the onset of the disease takes place at a young age the retardation is greater. If the disease comes on at maturity the intellectual functions do not show any defect.

There is no effective treatment for the acute state and many patients die during the early stage of the disease. With the best re-education and training children do not recover completely, and hardly one-third recover to make suitable adjustments to society.

### *Epidemic cerebrospinal meningitis*

There have been outbreaks of this disease in Europe and about one per cent of first admissions to mental hospitals are found to be suffering from this disease. Two per cent of the cases of mental deficiency are traced to meningitis. The disease is caused by the inflammation of the meninges or membranes covering the brain cortex by an attack from micro-organisms. Some of the physical and psychological symptoms are undue fatigue, weakness in muscles, blurring of vision, and lack of sleep and appetite. The severity of these symptoms depends on the pre-existing neurotic and



psychotic trends in the personality of the patient. Effects on children are more serious because their brain damage hinders the development of their mental functions.

### *Psychoses connected with brain tumours*

A tumour is a new growth in which the body tissue is abnormally enlarged. Such tumours are likely to be found in the breast, intestines and the like organs of the body. Between the age forty and sixty years tumours are found in the brain of adults. Some tumours are so malignant that they destroy the body or brain tissue, others only exert pressure on the bodily parts. Since the skull is hard even a small tumour may cause great pressure on the brain and interfere with work. Brain tumours are often surgically treated but when they are responsible for psychoses they constitute hardly one per cent of the mental patients admitted to hospitals.

Brain tumours effect far-reaching changes in the personality make-up of the individual. He becomes irritable, his memory is impaired, he is very excitable, confused, depressed, he may have hallucinations, convulsions, euphoria, mental retardation or apathy. Tumours in which special sensory areas are involved may produce hallucinations of sight, hearing, taste, and smell.

Treatment of brain tumours is primarily a matter for surgery and cannot be treated here.

### *Psychoses connected with cerebral arteriosclerosis*

Arteriosclerosis means hardening of the arteries and cerebral arteriosclerosis means hardening of the arteries of the cerebral cortex so that they can no longer carry adequate supply of blood to the brain cells, and when the cells do not get enough nutrition they waste away. Mental disturbances which arise as a result of arteriosclerosis of brain cells and tissues are being considered under this head. Large patches of fatty and calcified material appear in the inside layers of the blood vessels and gradually block the arteries thus preventing adequate circulation and nutrition.

The old impression that this psychosis appears in persons doing intensive brain work does not appear to be correct as this disorder is prevalent among illiterates and people of lower stratum of society. The question why some persons are more prone to suffer

from this disorder has not been answered yet. It becomes all the more difficult when we consider that some people never suffer from psychoneurotic trouble and yet suffer from this psychosis. Possibly heredity, too much eating and drinking, lack of sufficient rest and worry are some of the factors responsible for it.

It is one of the most common disorders. It accounts for 12 per cent of the admissions to mental hospitals and it is estimated that two per cent of the general population of either sex will develop this disease in their lifetime. Studies made in the United States show that this disorder is becoming more prevalent.

The disease may occur at any period after the middle age and the average age of patients as recorded in the United States falls between sixty-five and seventy. It is more prevalent in towns than in villages.

*Symptoms* : The onset of symptoms may be sudden or gradual. Sudden attack or "stroke" is reported in about half the cases. These show either blocking of an artery or haemorrhage and patients show marked clouding or loss of consciousness, inability to see time and place, and temporary paralysis of one side of the body. Total blocking of the artery may occur at night when the patient is asleep or after a heavy meal. Haemorrhage is more likely to occur when the patient is excited, hard at work or straining at stool.

On the physical side, the most frequent symptoms are dizzy spells, headache, undue fatigue, sleeplessness and convulsions. Common mental reactions are loss of initiative, decreased capacity for work, irritability, depression and mild memory disturbance. When the disease grows worse these symptoms grow more severe. The patient becomes forgetful and may show signs of intellectual deterioration or weakening. There may be decrease in interest and attention, judgment is impaired and the patient is aggressive, quarrelsome, afraid of losing health and mental powers. He may openly speak of committing suicide, and be very unstable in his emotions. Intense anxiety, rage and fear are common. He has his clear moments and a fair insight into the nature of his trouble. There is some change and difference in the nature of the symptoms depending on the part of artery affected. Damage to the left cerebral hemisphere leads to speech disorders.



We know very little about the causes and prevention or treatment of cerebral arteriosclerosis. Sometimes there is spontaneous improvement or recovery, but the chances are generally unfavourable and death rate is high.

### *Psychoses of old age or senile psychoses*

Old age is a period of all round decline, both physical and mental. Some of the normal changes are confusion, failing memory, too much anxiety about one's health, irritable temper, unstable emotions, narrow interests, fear of death, suspiciousness, great selfishness and extreme conservatism. Old people are highly opinionated and do not change their mind easily. These personality traits result from the degeneration of brain and diminished capacity for work. Such changes are normal and old people are generally looked after at home. But in some individuals these symptoms are exaggerated and are known as *senile psychosis*. Mental deterioration worsens and the patient is not capable of looking after himself or managing his own affairs. His behaviour is not only a source of annoyance but also of danger to others. What is the proportion of such patients to total admissions to hospitals is not known, but it is estimated that one per cent of the general population suffer from senile psychosis. The average age of patients admitted to mental hospitals for senile psychoses is between seventy and seventy-five years. The percentages are similar to those for psychoses of arteriosclerosis.

In senile psychoses symptoms are exaggerated forms of the symptoms for old age. Judgment is grossly impaired, memory and understanding suffer so much so that names of even close friends and relatives are forgotten. They cannot read or enjoy reading because they will not remember what they read before and cannot connect thoughts. Recent memory suffers much more. Retention of even very recent events is difficult. They are not able to carry on conversation and may repeat what they said just before. If they go out for a walk they may lose their way, get confused and bewildered. They are mostly self-centred and have very weak interest in others. They are easily flattered. Anxiety, agitation, restlessness, indifference and depression are common. If thwarted they become too aggressive and even abusive and ready to attack.

They stick to their habits and ideas, and cannot tolerate those who differ from them. They are mean, miserly and greedy. Some of them get unduly interested and may rush into foolish marriages. They indulge in silly chatter, sleep is disturbed, they feel dizzy and have attacks of apoplexy.

Treatment is confined to good care and nursing. Very few people recover and death rate is high.

### *Psychoses due to injury*

Head injuries and gunshot wounds leading to brain damage have provided rich material concerning mental functions and disorders. Hippocrates and Galen in ancient times considered injuries to the head and the brain as major causes of mental disorders. Head injuries are common in modern life in view of the numerous road accidents which have become a daily feature. But the number of people who seek admission into mental hospitals as a result of head injuries is very small, hardly 0.4 per cent of all first admissions. Page calls them *traumatic psychoses* as head injuries are a serious shock.

Ordinarily the brain is very well protected by the skull which is hard enough but even then a hard blow may break the skull and exercise pressure on the brain. Even if the blow is not very hard it may rupture some of the blood vessels causing haemorrhage. The symptoms resulting from brain injury depend on the nature and extent of the damage done to the brain. It is difficult to enumerate and describe here some of the major types of fractures and concussions which occur as a result of head injury, but a broad outline of the symptoms is all that is offered.

Immediately after the head injury there is confusion and headache, memory is disturbed and emotional instability is frequently found. In severe cases the individual undergoes a great change in personality and temperament. There may be loss of memory, convulsions and increasing mental deterioration.

Where the brain damage is extensive the general intellectual level of the patient is very much lowered. Injuries in different regions of the brain damage the corresponding mental functions and sensory activity.



Treatment of brain injuries is primarily a matter for the medical men and there is not much that psychiatry can do.

### *Psychoses with pellagra*

Certain types of psychotic disorders are due to acute deficiencies of some important vitamins particularly vitamin B complex and are incidental to pellagra disease caused by acute deficiency of vitamin B complex. It is marked by skin lesions, disturbances, of gastrointestinal tracts and a number of mental conditions. In mild cases the symptoms are the same as in neurasthenia with complaints of fatigue, insomnia, anxiety, apprehensiveness, forgetfulness, lack of enthusiasm and inability to make continued effort. In more severe cases memory is impaired and there are hallucinations, the mind is confused and adjustments to environment are disturbed. In still more severe cases there may be manic reactions, agitated depression with paranoid reactions. Such symptoms clear up or are relieved by proper diet and careful nursing. Nicotinic acid given in large doses works wonders and relieves these symptoms very quickly. Green vegetables and strong doses of vitamin B complex are recommended.

### *Psychoses with Huntington's chorea*

This is a disease of the nervous system which was first differentiated by Huntington of America. It occurs in adults between 30 and 50 years old. It is marked by progressive chorea, a convulsive nervous disease with involuntary, irregular twitching movements; it is accompanied by mental deterioration, ending in dementia and death. Of the patients admitted to mental hospitals it accounts for .01 per cent.

The physical symptoms include irregular twitching movements which become increasingly widespread and violent as the disease becomes more severe, the patient makes grimaces in the face, has a jerking, irregular manner of walking, he frequently smacks his tongue and lips and speaks in a slow, indistinct and explosive manner. Mental symptoms too are present. Memory is impaired, the patient is irritable and depressed, and cannot judge properly. There are no delusions or hallucinations but the patient feels so indifferent

and depressed that he is inclined to commit suicide. Later when dementia comes on some delusions too occur.

In twitching movements all the muscles may be involved, the head may twist this to that way, and the hands are always making jerky movements. Such movements are not painful but the patient cannot check them even if he tries, he has no control over his movements. They stop only when he goes to sleep. His emotional and intellectual activity gradually declines and he is listless and depressed. Investigations by neurologists indicate that there is general deterioration in some area of the brain.

The cause of this progressive disease involving degeneration of brain is not known but is generally attributed to heredity. The disease is known to run in families showing a previous history of the disorder. The actual degeneration occurs in the cerebral cortex. If all parents who suffer from this disease refrain from having children the disease would be abolished in one generation. Symptoms appear in adult life.

There is no known treatment for this disease. It may continue for twenty years during which there is an increasing degeneration of both mind and body till death occurs.

### *Psychoses due to drugs*

Addiction to drugs is very widespread. In the United States the extent of drug addiction is measured by the admission to hospitals of those patients who develop psychotic symptoms as a result of drug addiction, but what about those who do not develop such symptoms. In India drug addiction is no less prevalent though no count of people addicted to drugs can be made. It is an admitted fact that life is not easy for man on this planet and problems and obstacles to our task of living happily are often insuperable. People take to drugs because they are too timid or too sensitive for this world. The drugs most commonly used are morphine, heroin, cocaine and marijuana.

From the earliest records we know that opium and certain other narcotic drugs like hemlock have been used by man in search of solace and peace of mind. Many medical men in the past used such drugs to cure physical and psychological ailments. Even



today compounds of opium are being used extensively in all medicine. There are other drugs too like bromides or barbiturates which produce toxic conditions but they do not lead to any psychological symptoms.

In some parts of the world, drug addiction presents a formidable problem. China has been a big den for opium eaters and in the Far East countries and India the use of opium and other narcotics is fairly widespread. There are restrictive laws in many countries but many more people circumvent these laws and there is large scale smuggling of such drugs.

Psychoses connected with drug addiction account for only one per cent of the first admissions to mental hospitals. It is much higher for men than for women.

Drug addiction may occur at any age but it is more dangerous for young people than for grown-ups. Most people take to it between 20 and 30 years of age. Very few people take to drugs after the age of 50. It may be that young people seek new adventures and excitement, new thrills and experiences, and the old people have reached an age of established habits and do not wish to change. People take to drugs to seek emotional relief when they are all at once cut off from the protecting hand of their parents, wives or friends.

The nature of symptoms of drug addiction vary with the nature of the drug, the amount of drug taken and the personality of the drug addict. Therefore, we will consider each of the drugs separately. We shall discuss alcoholism in a separate chapter.

In a general way it must be pointed out that drug addiction serves the same purpose as hysterical symptoms, being a means of escape from life which is too difficult or distressing, whether objective or subjective problems. In course of time the use of drugs becomes compulsive and involuntary. No matter how one starts taking a drug, its continued use is an escape from the oppressing realities of his vital situation. The more he uses, the more he needs till he adds to the dose and becomes too weak to meet his problems. The vicious circle is started. Because these drugs cannot be obtained easily and legally, the drug addict soon becomes an easy victim of unscrupulous pedlars who extract enormous

payments for their contraband. He may have to face disgrace. Painful periods of the withdrawal of the drug are followed by succeeding depression and the temptation to use the drug returns with an overpowering strength.

Addiction to drugs is found in all classes of people, most of them are found to belong to the underworld. Males are in greater number. Addiction is less common among married people than among widowed, divorced or unmarried people.

### *Opium*

Morphine and heroin are the principal derivatives of opium and they enter the human body either by way of mouth or by smoking or inhaling or by injections. The eating and smoking of opium is a very ancient practice. It helps to deaden pain and provides relaxation and sleep. When a small dose is taken for the first time it produces drowsiness, but the person has a very clear mind as long as he is awake. His pain is relieved. Voluntary movement is diminished and so is sex desire. The patient passes into a state of joy, peace, relaxation and euphoria. He has happy dreams and phantasies. Mental processes are quickened and the person has sense of time and distance. He considers his passing thoughts as very bright ideas. The emotional state is one of contentment and peace, and the patient wakes up from sleep quite fresh and relaxed. In the initial stages when the patient takes only a small dose sleep is sound and dreamless. If the dose is increased the patient goes into a state of coma, and a greater over-dose leads to death. De Quincy has reported very vividly of his own experience of opium-eating. He seemed to descend into chasms and sunless abysses "depth below depth," from which it was difficult to come back. The sense of space and time were greatly affected. Buildings and landscape were magnified manifold and he felt like passing out into eternity. De Quincy testifies that he seemed to have lived 70 to 100 years in one night. These pleasant effects continue for 4-5 hours and when the effects of the drug wear off there is another craving for another dose of the drug.

About thirty days or so is enough time during which the drug habit is firmly established and the person becomes physiologically dependent on the drug in the sense that he becomes ill if he does



not take it regularly. In course of time he develops tolerance to the drug so that larger and larger doses are necessary for desired effects.

If opium addicts do not get their regular dose within 12 hours they experience painful withdrawal symptoms. The nature and severity of these symptoms depends on many factors including the amount of the drug taken, the interval between the doses, the period for which the drug has been taken and the health and personality of the person. The first symptoms to be noted are that the patient feels restless, he may yawn, sneeze and perspire profusely, he has no flashes, chills and digestive disorders. Later there is an increased desire for the drug leading to depression and fear of some disaster coming ; the patient is irritable, feels weak and has a higher rate of respiration. With time these symptoms grow more severe ; there may be chillings alternating with sweating, vomiting, diarrhoea, abdominal cramps, pain in the limbs and the back, bad headache and tremors. The patient refuses to eat or drink and this leads to further loss of weight and weakness. In more severe cases the patient may have delirium, hallucinations, even manic reactions. His heart grows weak and may fail resulting in death. During this period of symptoms if opium is given to the patient at any time, his health and peace of mind return in a few months.

Such symptoms usually reach their worst point in three to four days if no opium is given or taken. On the fifth day they begin to decline and disappear by the eighth day. Then the patient starts taking his usual meals and his craving for the drug also subsides. But if he takes his old large dose he may die. Many people undergo treatment so that they may begin with small doses again.

Now and then one may come across a person who continues to take very small doses, feels normal and does his work with usual efficiency. Many famous persons were opium eaters without their closest friends knowing about it. But this is very rare indeed. Usually the dose goes on increasing, the patient loses social dignity, degrades himself to obtain the drug from undesirable people, and may have to lie or steal. Other people also begin to avoid him and he is in a way rejected by society. His moral, intellectual

and physical standards fall and he usually degenerates as a human being.

Many studies of opium addicts have been made in the West and they all show that these symptoms by themselves may not be an indication of the person's degeneration ; rather lack of nutrition, loss of money, social position and self-respect may be responsible for it. Confirmed addicts are often found to be irritable, depressed, suspicious, unstable and morose. Drugs may not be the actual cause of the mental disorder, and the fact that a person takes to drugs may itself be the cause of some psychotic trends present in his mental make-up.

### *Cocaine*

Cocaine is a drug prepared from certain types of coca trees and is often used in place of opium when the latter is not available. It is also a habit forming drug but it is different from opium in one important aspect. With cocaine there are no severe withdrawal symptoms as in opium when the dosage stops. Tolerance is not increased with its continued use and there is no specific physical craving for the drug. Consequently it is not quite correct to speak of cocaine in drug addiction. But psychologically the patient comes to depend on it fairly badly enough. The drug is usually taken by snuffing it.

Cocaine is usually taken in company and the habit of taking it is always acquired through association with other addicts. One very good reason for doing it is that it is a strong stimulant and has strong stimulating effect on sexual processes. It seems very necessary that such stimulation should take place in company. People with sex perversions use it as a means of seducing others or for promoting interests and conditions which will provide scope for their sexual delinquencies and perversions.

Small doses of cocaine produce a sort of euphoria and great exhilaration, and the group taking it together produces a climate of boisterous drinking set. All the members of the group are highly active and jolly, and indulge in glib talk about all sorts of things. All sorts of ideas are floated and the party is highly convivial. But as the effects of the drug wear off and the stimula-



tion weakens, there is depression, the person is irritable and there is an all-round weakness.

Those who get into the habit of using cocaine often have to meet people of questionable and undesirable ways to procure it. They lose all self-respect and are often known to be indulging in abnormal and immoral sexual behaviour. Cocaine pedlars are notorious for exacting exorbitant prices from their customers on the plea that it is getting more and more difficult to get it. Continued use of cocaine produces severe moral degradation.

Strong doses of cocaine produce cocaine hallucinations in which the patient has terrifying visions. He may report that certain things are crawling under his skin and that some worms and insects are coming in and out of his body. He may have paranoid ideas. Because the craving for cocaine is psychological it is even more difficult for treatment.

### *Marijuana*

This drug is obtained from the dried flowering tops of the hemp plant. It is also known as *hashish* or *loco weed*; *Bhang* or *Ganja* in India is a variation of it. The principal methods of taking it are either by eating the dried leaves of the plant or by smoking it in special marijuana cigarettes known as *reefers*. The use of marijuana does not involve any increased tolerance or withdrawal symptoms nor does its use lead to any specific physical craving. It produces exhilaration and euphoria the patient imbibes greater self-confidence and has a pleasant feeling of relaxation and contentment. He has a sensation of floating away. His intellectual and motor efficiency is impaired, his perception of time and his moral judgment is very much lowered. Under its influence he is inclined to be talkative and exuberant. There is a feeling of increased strength and power. Some writers emphasize that marijuana has a marked effect in stimulating sexual processes but this may be due mostly to the feeling of exaggerated vigour on the one hand and the weakening of the moral inhibitions on the other.

Many reckless acts in driving and other anti-social activities due to marijuana intake may also be due to the intensified feeling

of self-confidence and adequacy which it produces. Some musicians also use it to offset monotony and to improve their rhythm. Although many people report that they are able to do things better with the intake of marijuana in the long run their efficiency is very much reduced.

The individual feels a peculiar sense of unreality prevailing in his mind and he is very much amazed at all that is happening around him and by what he thinks under the influence of this drug. He is thus able to drown his worries. There is also the experience of dual personality and he is able to see himself as an intoxicated person. One part of his personality is able to judge and criticize the other part.

When the patient passes into a state of delirium he has a large variety of illusions and hallucinations connected with sight and hearing. His sense and understanding of the surrounding world is very much distorted. He has confused notions about the space relations of things and time, but he hears even very low sounds. If the dose is large, the patient passes from a state of delirium into a state of drowsiness and sleep, extreme weakness and fatigue.

Even if marijuana is used over a long period of time it is not known to have any harmful physical effects in and by itself. But the drug is expensive and the illegal way in which it has to be obtained and the social disgrace which attends it are sure to demoralize the person, to lower his sense of moral values and his moral judgment. His nourishment suffers and his health becomes poor. Many individuals do not stand marijuana well with the result that their behaviour is very bizarre and pathological similar to that of a person drunk. It may lead to psychotic reactions.

Some persons after taking marijuana develop a delirious rage and do acts of violence. It is said that in the middle age people took *hashish* before indulging in religious murders. The sudden stoppage of the use of marijuana does not involve withdrawal symptoms. Though hemp and its compounds are included in addiction drugs modern psychiatry is of the view that it is not so addictive as is commonly supposed, and the number of its users is much larger than is readily accepted. There is no physical craving for it, even after long and regular use the addict does not feel the



need of increasing its dose and as has been pointed out stopping its use does not lead to withdrawal symptoms. The addict is bound to wonder why this drug should be classed with drugs like opium and heroin but law does put it on par with the opiates. It is believed that to such a person turning to opium for the sake of an experiment is a short step, though it will later turn out to be a large step. There is a deep prejudice against drugs outside alcohol and it is not likely that restriction on the use of this drug will be removed or reduced.

### *Mescaline.*

There are many drugs which are used for experiments or therapeutics and which have main or side effects which provide the bored, the curious or the unhappy with welcome or interesting sensations. Mescaline is one of them. It is obtained from the buttonlike top of a certain type of cactus plant. It is usually taken by mouth and is a strong stimulant. It leads to a prolonged state of wakefulness and removes all fatigue. In suitable subjects it produces a fascinating though somewhat alarming psychotic condition which includes in its manifestation hallucinations, illusions, distorted colour, space and time perceptions, and sometimes a phenomenon called *synaesthesia*, which means the transfer of one kind of sensation to another modality—the sound of a violin may induce reddish-brown hallucinations or the sight of blue steel may cause a cold sensation to spread over the skin. Extremely beautiful and vividly coloured images succeed one another in a fascinating manner.

Experiments made with certain people indicate that mescaline is capable of inducing typical psychotic symptoms including quick changes of mood, paranoid reactions, split in personality and disorders of thinking and behaviour. The drug is not really habit-forming and it is doubtful if its prolonged use has harmful effects.

### *Bromides*

Bromide and its compounds are sedatives which relieve tension, induce relaxation and sleep, but if they are continued over a long period of time they may produce psychotic reactions. In mild mental intoxication the symptoms are confusion, tiredness, lack of concentration, disturbed memory and lack of sleep. Speech

too is slurred, digestion is upset and there is little appetite. There are eruptions on the skin. In severe cases there is delirium, fear, defective adjustments and hallucinations. Treatment consists of taking bromides out of the system and this is done by giving large quantities of common salt in water. The patient is generally cured in ten to fifteen days.

Bromides are also given to reduce sexual desire and in epilepsy as a sedative.

### *Interpretation*

The percentage of people addicted to drugs is small. Usually drug addiction indicates some personality defects, ill-health or maladjustments. Broadly speaking there are four kinds of drug addicts, those who get into it by accident but are quite normal, those who are psychoneurotics, those who are having one or the other type of psychosis and anti-social characters who take to drugs as a part of their psychopathic behaviour. Some addicts may be included in more than one class. It is not possible to go into a detailed analysis of drug addicts.

*Treatment* : Only a very small percentage of drug addicts are ever completely cured, a good many go back to it thus demonstrating that there are certain traits in their personality which incline them to the drug habit. Psychotherapy is of the utmost importance because permanent cure is possible only if the patient is carefully helped to build up strong psychological defences against the strong habit. For those individuals who acquire such habits accidentally the prospects of cure are greater. While it is necessary to exercise control over the use of such drugs and this can be done only by the state, society should be fully conscious of the needs of mental health of the people who take to drugs. Fortunately our country is gradually realizing the importance of mental health needs but the programmes are very unrealistic and the provision is ridiculously meagre.

## QUESTIONS

1. What is general paresis? Discuss its symptoms and treatment.



2. Discuss juvenile paresis, cerebral syphilis and epidemic encephalitis.
3. Describe psychoses connected with brain tumours and cerebral arteriosclerosis.
4. Old age is a disease, discuss this statement and the psychoses connected with old age.
5. Explain the following :
  - Traumatic psychoses.
  - Psychoses with pellagra.
  - Psychoses with Huntington's chorea.
6. Discuss in a general way the psychoses connected with drug addiction.
7. What are the effects of taking opium? Discuss the mental symptoms of an opium eater.
8. What are the effects of taking cocaine, marijuana and mescaline?

## Alcoholism

For too long in the history of mankind alcoholism was considered a moral problem, resulting from moral degradation and weakness of will power. That is why little or no progress was made in understanding the basic factors which underlie this habit or in devising effective methods of treatment. For equally too long in human history people have thought fit to exhort and advise alcoholics to give up drinking till our own times when people started treating it as a problem for psychiatry. Drinking is just one of the several ways in which people wrongly react to stresses and strains which are too difficult for them to meet in the normal manner.

Drinking is as old as the civilization. There is hardly any country or community, any age or culture in which drinking in one form or the other has not prevailed, and there are sections of society in which the use of alcohol is not only common but is also considered as a sign of respectability, modernism and what not. The use of alcohol is considered pathological if it is used in excess, if the individual cannot do without drinking, if its use is disapproved by society and if it has injurious effects on the mind and body of its users. As in drugs the individual using it soon begins to crave for it, consumes larger quantities and cannot be deprived of his daily or periodical drink. But in some individuals even excessive indulgence in it for a long period of time does not produce any mental disorder. So psychiatrists are driven to the conclusion that there must be underlying traits of personality which under the influence of excessive indulgence of alcohol are precipitated into psychotic symptoms. That is why alcoholics are classified according to their symptoms rather than on the basis of what and how much they drink. Modern psychiatric practice, however, lists several symptoms as definitely alcoholic in nature and we have a term *alcoholic psychoses* to denote such symptoms as excessive intoxication, delirium tremens, Korsakoff's psychosis, acute hallucinosis, and alcoholic deterioration.

*Incidence :* We are not concerned here with the problem of



drinking in general but with chronic alcoholics who have psychotic symptoms. In the United States nearly 10 per cent of the first admissions to mental hospitals are alcoholics and of them at least half have alcoholic symptoms. Nearly one out of every two hundred people in that country are expected to develop alcoholic psychosis at one or other time of their life. It is primarily a mental disorder of middle life. The average age of first admissions to mental hospitals is forty-five. The number of men is greater than that of women. A very high percentage of them are either widowed or divorced. Among men the proportion of bachelors is greater than that of married people. These figures are for the United States. There is no count for our own country.

*Why people drink :* Ethyl alcohol is the active constituent of all the intoxicating beverages used in the civilized world. It is taken in enormous quantities, and though the proportion of subjects who become addicted is small the absolute numbers who take alcohol are so large that alcoholism constitutes a public health problem of very great magnitude. However, a distinction must be made between the alcoholic and the person who takes a drink now and then. An American helps himself to a cocktail as an appetizer before his meal and in Europe people take a glass of wine of one kind or the other with their meals. In other countries all over the world people take a peg to rouse themselves. These are not alcoholics but just moderate drinkers who do not have any irresistible craving but because they seek some very welcome effects of alcohol : the feeling of relaxation and warmth which has a very pleasant tone, mild mental and emotional stimulation, freedom from restraint, euphoria and a feeling of well-being, cheerful fellowship and camaraderie. These things are socially desirable and personally very pleasant. Social advantages are nullified when relaxation changes into inertia, reduction in restraint into tactlessness and debauch and good fellowship into silly talkativeness. Even the personal enjoyment does not last long when the next morning the drinker has a hang-over—headache, lethargy, nausea and tremulousness which are generally not experienced except in illness. The alcoholic has strong craving for alcohol at certain times during the day and usually indulges in excess. His reasons for drinking are deep and complex.

While the urge to drink is never inherited studies of alcoholics have revealed that about 40 per cent of the alcoholics have had relatives who were either alcoholics or had other abnormal trends in their personality. There may thus be some constitutional basis of alcoholism in the sense that some psychological factors in the personality of the individual may incline him to take to alcohol. Some persons may be constitutionally inclined to solve their problems and difficulties by taking to the use of alcohol but that does not necessarily imply that they will become alcoholics. No individual becomes an alcoholic simply because his parents or relatives were so. Other influences must be operating to that end.

Psychologists explain the drink habit by the purpose drinking serves. People drink to escape from worry, anxiety, responsibility and misery, which domestic, occupational and social life brings, to drown their sorrows and griefs, to overcome their boredom and lethargy, to forget painful and embarrassing experiences and to make up for their inferiorities. Under the influence of drink the timid feel brave, the diffident feel great self-confidence and the unhappy feel cheerful. It helps to overcome frustrations and disappointments. All this may be true but it is not a complete explanation. Everybody in this world has problems and worries. In fact it is most pertinent to ask : who has not? But why is it that only some take to drink to meet their problems and worries, and others don't.

*Some theories :* Many psychoanalysts explain alcoholism by repressed homosexuality. They argue that men drink excessively mostly in the company of other men and in such bouts they come in bodily contact with each other. In such bouts of excessive consumption of alcohol the repressed homosexuality of the alcoholics finds expression. Such hallucinations as they have under the influence of alcohol give indirect expression to thoughts, wishes and urges as bear on repressed homosexuality.

One psychoanalyst K. A. Menninger puts forward an interesting theory. According to him addiction to alcohol is partial suicide, it is an attempt at self-destruction so that greater self-destruction may be avoided. He sees in the thwarting of his ambition, disappointments in love and business, threat of disgrace



and the like a great danger to himself, and, therefore, indulges in milder self-destruction to avoid a greater one.

These and other theories are not a very comprehensive and complete explanation of why people drink but they throw a good deal of light on the problem. They fail to account for individual differences in the use of alcohol and are too simple to be accepted as a satisfactory explanation of the behaviour of alcoholics. The two theories mentioned above may account for the motives of some alcoholics but cannot explain the addiction of others. Many people drink alone and secretly and there is no homosexual indication. And what about women alcoholics? Regarding the theory of partial suicide it is not understood why some people take to this method of suicide.

The most striking fact about the use of alcohol is its great popularity in all cultures, regions and countries and among all classes of people. As has been observed earlier in all civilizations people have sought pleasure in drinking one kind of alcoholic beverage or another. Many campaigns have been organized against it, many legal restrictions have been placed on its use, laws of prohibitions have been enacted, temperance societies have waged ceaseless war against its use and almost every religion has propagated against it and yet it is as popular as it ever was before. The fault was with our interpretation of alcoholism. We naively believed that drinking is just a matter of habit, governments enacted their prohibition laws on this basis believing that by keeping people from becoming habituated to alcohol by cutting off the supply the habit of using alcohol will soon disappear. It is an experience of all governments and the committees they appointed to go into the question that prohibition helped to increase alcoholism and probably the use of other drugs along with it.

A fairly large number of alcoholics do like the taste of alcohol and take lot of trouble to conceal it. Therefore, the attraction of alcohol does not lie in its taste but in its effects. Let us study what these physiological effects are.

Alcohol, contrary to popular belief, is not a stimulant but a depressant. It attacks and paralyses the higher centres of the brain thus weakening their control on the lower centres. As

this control weakens the primitive impulses and emotions of man are no longer restrained and get a free expression. Thus the drinker is able to indulge in free expression and satisfaction of primitive impulses which were held in check by the restraining hand of intelligence, memory and judgment. With critical powers numbed and social inhibitions abolished the person forgets his obligations and responsibilities, failures and defeats, disappointments and miseries. Alcohol helps him throw off the restraining influence of memory, intelligence, social sense and conscience. He allows himself to drift with his true feelings, emotional and inner urges. Thus alcohol is a means of escaping from one's rational and social self, from the real world of hardships and threats, worries and fears into a new world where what one feels most is all that really matters. Before drinking he was frustrated, depressed, anxious and bored ; after drink he feels warm, vigorous, hopeful and happy. He now feels quite capable of accomplishing tasks which he avoided. Drinking produces a sense of security and competence. Such a theory is more inclusive and comprehensive than the theories we have mentioned above. But it fails to account for individual differences in drinking habits or to explain why some people become addicts developing psychotic reactions and some people do nothing of the kind, why some people are very easy to persuade to drink than others, why some are more sensitive to the influence of drink and go over with one peg and others are more tolerant of it and need many more to get drunk.

And in general and on the whole the effects of alcohol are very injurious. When the alcohol content of the blood rises to 0.3 per cent serious disturbances in movement, speech and vision are seen, and thinking is confused. And when it rises to 0.5 per cent the entire physiological and neural balance is upset and the person becomes unconscious. This unconsciousness in a way protects him from more serious consequences because he is prevented from consuming more alcohol which may bring about his death. From this we may infer that it is not the amount of liquor consumed which intoxicates a person but the alcohol content absorbed in the blood. The effects of alcohol vary with the individuals, their physical conditions, their personality, the amount of food he has already taken and the time for which he has been drinking. There are many



people who consume quite a large quantity of liquor but show no signs of intoxication and retain their bodily and intellectual alertness. Much, therefore, may be said to depend on the attitude of the person. Not all people on intoxication become joyful, expansive and happy. Some grow so sad that they blurt out their secret miseries and worries, others feel drowsy and go to sleep and still others become suspicious and irritable.

The actual effect of alcohol on the brain centres is not fully known but it does not seem to cause damage or injury to the brain tissue. But it does seem to slow down the functioning of the brain, particularly those centres which deal with understanding and judgment, and later those which deal with movement and their co-ordination.

Some writers think alcohol is a poison which has a very harmful effect on the physical organism. But others maintain that alcohol is a high calorie food. Once alcoholism is absorbed it enters into carbohydrate metabolism and may provide energy for the usual activities of locomotion and maintenance of body temperature ; it may indirectly supply fuel to the intellectual activity. In some people excessive consumption of alcohol may cause cirrhosis of liver but it does not have any harmful effect on other organs. It has no bad effect on heredity or potency, on brain or heart. But the trouble is that alcoholics do not stop at any limit, they want more and more and increasingly depend on it, it is their food and nourishment. Naturally, therefore, they miss the several vitamins, and have lower bodily resistance to disease and it shortens life. Excessive indulgence over a period of time leads to abnormal behaviour, to psychotic reactions. Though we do not know how these psychotic reactions are related to alcoholism they have been found in alcoholics.

*Personality factors :* It is difficult to say what traits or factors in personality favour the development of psychotic reactions in an alcoholic because attempts to classify alcoholics into clear groups have not been very successful. Alcoholics are drawn from all classes of people and all types of persons. Some people after a mild drink in the evening just to keep up company are found to be more extroverted and male drinkers are inclined to prefer

their mothers to their fathers, but these traits have no significance in the causation of alcoholic addiction.

*Social factors :* Some social factors contribute to the increase of alcoholism. How respectable is the drinking habit, how readily available the several varieties of liquor are will to some extent influence the amount of alcohol consumption in any country or society. In countries where wine is manufactured from grapes and is found in abundance people will drink mostly because it is freely available and cheaply sold. Prohibition may not altogether stop the use of alcohol but it certainly has a preventive effect. Reports from the United States indicate that during the early days of prohibition when alcohol was scarce the number of alcoholics admitted to mental hospitals fell appreciably. In higher social circles more and more people are taking to drinking as it is considered a mark of respectability and modernism, of smartness and sophistication.

Women are less susceptible to the temptation of liquor. It may be their training or social pressure. The number of male alcoholics admitted to hospitals is four times larger than that of women. Among Indians there are certain castes and sections in which wine drinking at festivals and ceremonial occasions is socially enjoined and there are very orthodox sections which scrupulously shun it.

Drinking is very common among motor and truck drivers and some states in the west and some large towns in India are faced with the problem of intoxicated drivers being a menace on roads particularly at night. But here we are not concerned with social problems arising out of alcoholism but with problems of psychiatry.

*Alcoholic addicts and non-addicts :* We have discussed why people drink and considered mostly those who drink for the pleasure of it or to combat symptoms of anxiety, fear and inferiority. They can be described as addicts. The addicts drink to excess and cannot resist the desire to drink more and more ; they damage their career and their families, they may develop cirrhosis of the liver, and not only do they have psychological dependence, but their tolerance rises and they either show withdrawal symptoms on abstinence



or lose control of their intake. How the heavy drinker becomes an addict may be described in his several stages of progress to that end.

To begin with he is a lonely and sad person, he takes to drinking as a means of obtaining some solace and he spends a good deal of time and money drinking with other people. He justifies all this by thinking that he has not got much out of life and that he needs some pleasure to get a kick out of life. His tolerance rises and he consumes increasing quantities of liquor. From one to two, two to four and four to six glasses does not take long. If his companions take less he enters the bar earlier or leaves it later to have extra drinks. He knows what is happening to him. The only way he can escape is through abstention but that seems a very cruel thing to do. In a few years he becomes a patient whose life revolves round alcohol, he has no control over his life, he goes on drinking not the whole evening but the whole night stopping only when he is too wretched, too drunk and too broke. There may be spells of abstention during which he feels ashamed and repents, but he feels gloomy, agitated and depressed. He is compelled to rationalize his drinking habits and makes many pious resolutions about taking less. He starts again, and after a few bouts again there is a spell of remorse, misery and self-reproach. He may turn upon his family, friends and the doctor for his plight, and on the slightest provocation quarrels with them and returns to the bottle. During drinking he may develop paranoid reactions and make grandiose suggestions and become generous and expansive. He is trying to protect his self-esteem. He may offer drinks to his set and yet curse them for exploiting him. He loses interest in food and his efficiency begins to fall badly. His family life may collapse and he may turn more and more to the bottle. He may start drinking even in the mornings, may lose his job and may take to drinking larger quantities and more frequently. He goes down in the social scale and in degraded circumstances may reach "rock bottom". He can no longer hide his plight and failure, and may at last seek treatment.

This progress toward abnormal addiction may stretch into years, men may take 15 to 20 years while women reach the end much sooner, say three to four years.

*Alcoholic psychoses*

Psychoses associated with alcoholism can be conveniently classified into two groups, acute reactions and chronic reactions. Acute reactions have four sub-types: *pathological intoxication*, *delirium tremens*, *acute alcoholic hallucinations* and *Korsakoff's psychosis*. These we shall discuss in detail here.

*Pathological intoxication*: This type of reaction occurs in people whose tolerance to alcohol is very low. Persons suffering from epilepsy or mentally unstable persons, and normal persons who, due to sheer fatigue and emotional strain cannot stand even a small quantity of alcohol show signs of pathological intoxication after taking even a small quantity of alcohol. There are instances of people suffering from this disorder even after a glass or two of beer. In other cases a large quantity of liquor is necessary to induce this condition. The patient begins to have hallucination and is badly disturbed, he flies into a rage and threatens to commit suicide or murder others. He is utterly confused and there is a great danger that he may commit crimes of violence such as man-slaughter, attempted murder, arson, burglary or sexual assault.

It must have been clear from what has been said above that this reaction does not depend on the amount of liquor consumed. Some are affected even by a small quantity, others have to ingest much more to pass into pathological intoxication. This leads psychologists to infer that pathological intoxication occurs in individuals who have a psychopathic background, that is, have either some brain injury or are suffering from one of the mental diseases like schizophrenia, hysteria or epilepsy. It may also occur when a person suffers from deficiency in blood sugar.

After an attack of pathological intoxication the patient usually falls into deep sleep and on waking up completely forgets what he said or did during the time of pathological intoxication. There is great mental confusion during the attack and the patient suffers from outbursts of rage, but he does not recall anything about them afterwards.

The attack of pathological intoxication varies from a few minutes to a couple of hours and about ten per cent of the patients admitted to mental hospitals suffer from this reaction.



*Delirium tremens* : This is a classical consequence of excessive drinking over a long period of time and is the best known of all the psychotic reactions. It may also appear after an injury or debauch. It is supposed to follow a sudden cessation of drinking but this has been found to be questionable. For a day or so before the attack the patient is too sick to drink.

In some cases delirium tremens does not appear suddenly. Before its onset the patient is agitated and restless, and is unable to sleep, and a nervous apprehension and suspicion that indicate that the patient is ceasing to grasp what is happening around him and is, as a consequence, taking the only safe course in this unfriendly world and assuming that he is being caught. He is unable to sleep and has nightmares, and is frightened by sounds or impressions, particularly in the dark. His sleep is disturbed by vivid and alarming dreams. His consciousness becomes more clouded and he starts to interpret what he dimly sees and hears in such a way that his perceptions fit his mood of the moment, which is often one of fear and remorse. In other cases the attack comes on all of a sudden, and the patient loses adjustments to time and place.

The particular characteristics of delirium tremens are :

1. *Vivid hallucinations*, particularly of such animals as rats or snakes. Visual hallucinations often starting as illusion on seeing a crack in the wall, cause the patient's fear to increase to a point where he may cry out or try to run away. He may see small animals like snakes, rats, insects and all manner of horrid things like pink elephants emerging from the floor and rushing toward him or soldiers may march and countermarch on his bed. He may hear voices of loved ones who reproach him with his misdeeds and the patient is bewildered as to how he should explain their voices even though the room is empty and there is no one there. He is both frightened and fascinated by these hallucinations and objects of the real world are not able to distract him. Often such patients have hallucinations while driving a truck or gardening.

2. *Acute fear* : The patient is very much terrified by animals he sees in his hallucinations, but even otherwise he is in a state of extreme terror. These are "the horrors". The patient sees

these animals changing form, colour and movement and terrifying him. Or he may have a general dread that something very sinister is going to happen to him or that somebody is going to do him harm or kill him. This terror may induce him to try to commit suicide.

3. *Extreme suggestibility* : The patient may be suggested all sorts of things and he accepts them. He may be told that a certain animal is sitting before him and he will start doing something about the animal. Or he may be suggested pictures of animals on the wall and he confirms seeing them. He may even try to catch them.

4. *Disorientation about time, place and persons* : The patient loses track of time, may mistake the hospital to be his home or office and may start embracing medical staff in the hospital in the belief that they are his close friends or relatives.

5. *Marked coarse tremors* in hands, tongue and lips. This symptom is indicated by the name of the psychosis. Heartbeats become weak but rapid, the patient perspires profusely and there is foul breath from the mouth. There is no motor co-ordination and the patient is badly exhausted.

The delirium usually lasts from three to six days and is usually followed by deep sleep. When the patient awakens he has few symptoms though he is still scared. He may not resume his drinking for some time but goes back to it eventually. Ten to fifteen per cent patients die of heart failure or pneumonia or from sheer exhaustion.

The patient should be given complete rest in bed, with nourishing diet and lot of vitamin B Complex. Table salt should be given in large quantities. Deep sleep may be induced by sedatives, particularly in the case of agitated patients.

### *Korsakoff's psychosis*

The symptoms associated with Korsakoff's psychosis may appear in several other conditions like lead poisoning, cerebral arteriosclerosis or chronic alcoholism. They are impairment of memory for recent events, emotional instability, delirium and falsification. The patient may be unable to recognize things, pictures,



faces or rooms which he had just seen. He cannot remember what he saw a few hours back, but if you ask him a pointed question he will make up by filling gaps or inventing a story. He may give fancy details of what happened though he does not remember anything about it. He may have visual and auditory hallucinations. He may think he is in his office and start giving orders. His moods change, at one time he is irritable and moody and at others cheerful and expansive. The physiological symptoms include tingling sensation in the extremities, numbing of some areas of the skin, inability to raise his hand, his wrists may drop. The Korsakoff symptoms last a long time and there may be no improvement for six to eight weeks. In some cases the symptoms may become permanent. The best thing to do is to provide very nourishing diet and with high doses of vitamin B Complex. Some general deterioration in both physical and mental health persists, memory may continue to be impaired, intellectual and moral standards may remain low. Post-mortem studies of the brain have not revealed any organic lesions.

*Acute hallucinosis*: In this state the alcoholic hears very strange ominous voices at first from one person and later from several persons. There is insomnia and acute sensory sensitivity and anxiety hallucinations. The patient takes his hallucinations very seriously. The voices he hears are very reproachful, they criticize him and bring to light his innermost weaknesses, particularly those of sexual nature, and he is terribly afraid of being exposed and persecuted. He frequently hears them sharpening knives or getting ready their pistols, he hears their footsteps approaching to attack him in a threatening manner. He is so terrified that he cries for help or proceeds to commit suicide.

This condition may last for several days and even weeks. Illusions, suggestibility and restlessness are not so marked in acute hallucinosis and the patient is usually well-adjusted and conscious. Except for his hallucinations he is quite coherent in his speech and movements. After recovery he is able to recall events of his illness and is very remorseful about them. He is quite conscious of what he did during the trouble.

Twenty to twenty-five per cent of the first admissions to mental hospitals of alcoholic origin have acute hallucinosis. Most writers

believe that these symptoms are not directly connected with alcohol but are developments from schizophrenic trends of personality which were aggravated by the use of alcohol. Most of these patients have a long history of alcohol addiction extending from 12 to 15 years.

Treatment consists mainly of hospitalization, good nursing and nourishing diet.

*Chronic alcoholism* : Excessive use of alcohol over a period of many years brings about certain changes which are due to the toxic effects of alcohol on the brain tissue. Chronic alcoholism is a combination of general personality deterioration with such toxic effects which have accumulated with a long period of drinking. The symptoms vary but develop gradually. The patient is unable to concentrate his attention, his memory is impaired and his judgment is disturbed. He is irritable, brutal, over-suspicious ; he has no ambition, no will power, no interest in his personal appearance and no responsibility. He will look very amiable and cheerful but on closer approach will be found to be abusive and rude. He will curse his friends, relatives and colleagues. He is likely to tell lies and boast about his good deeds. He will appeal to people to give him money for his drinks. He neglects his family, is very sensitive about his drinking and will not tolerate any interference in his activities. He has no control over his drinking and offers all sorts of excuses to justify his drinking habit. Alcohol weakens his inhibitions and stimulates his sexual desire, and he is guilty of several types of sex deviations to the disgust and shame of his family. He becomes coarse in his speech and behaviour. With outsiders he is very sweet and courteous but with his own family he is bitter, hostile and cruel so that he makes the life of his wife and children a veritable hell. He may indulge in exhibition or assault. If he works at all, his work is poor ; he is unreliable and inefficient and he is most likely to give up or lose his job. It is difficult to say what part of his symptoms are psychogenic and what are due to his ingestion of large quantities of liquor. Frequently what symptoms chronic alcoholics develop depend on the personality traits they had before taking to excessive use of alcohol.

Some common physical symptoms are reddening of the face



and the nose, flat face, flabby muscles, impaired physical strength, tremors, cirrhosis of the liver, heart disease, nephritis.

*Interpretation :* Before we take up a discussion of some of the techniques of treatment it is better to recall some of the main contributions psychiatry has made to our understanding of the problem of alcoholism.

Alcoholism is essentially a disorder for psychiatry to handle. Religious and moral preaching and advice may help but it is primarily a problem for psychiatry.

It is no longer held that alcoholism is a matter of weak will-power or some weakness by inheritance or birth.

It is no longer held that alcohol is the sole cause of alcoholic psychoses. We know today that alcoholism is merely a symptom of some underlying personality maladjustment.

People drink for a large variety of reasons and the only common thing they have is that they drink alcohol.

In trying to explain alcoholic disorders, therefore, we must look into all possible causes and not be deceived by the all too prominent fact that they all use alcohol.

*Treatment and prevention :* It is very difficult to treat habitual turning to alcohol. When sober the drinker will make all sorts of promises and resolutions to stop drinking but when he feels restless, depressed and anxious he is unable to resist the temptation of passing into a pleasant even though unreal world with the help of the bottle. This cycle goes on till he firmly believes that he cannot do without it and it is after all not so bad a thing. Elation and uneasiness alternate till addiction is established and outside help is considered necessary.

As has been pointed out above the moralistic approach is quite useless. However ashamed and remorseful he may be made to feel he returns to the bottle. Rather the greater the shame and remorse the more readily he returns to his drink at least to drown his shame and remorse. Exhortation and preaching do not have any effect. Punishment and convulsive therapy have also proved of no use.

Today the methods of treating alcoholism have undergone a basic change. Drinking is no longer considered the cause but the result of a person's difficulties. The reactions and after-effects of heavy and prolonged drinking may need medical treatment in the form of sedatives, hot baths, toning up the system by washing and resting his stomach and giving him nourishing diet. Even in very severe reactions of chronic alcoholism efforts are made to improve the physical health of the patient by making up vitamin deficiency, and removing organic defect, if any. But a detailed course of psychotherapy is necessary to strengthen the individual's defences against the difficulties and miseries of life. This psychotherapy should be undertaken in a hospital so that the patient is removed from those stress situations in which he feels the urgent necessity of drinking and his physical and mental difficulties are well looked after. A change and control of environment will reduce the prospect of a relapse into alcoholism. But whatever treatment is pursued the patient must be taken off his drink habit completely.

Methods of psychotherapy may be grouped under three heads. In the first group we have the various forms of surface treatment such as suggestion, moral encouragement and persuasion, and hypnosis. Some times these techniques produce good results. During the hypnotic state the patient is given a suggestion that he will not drink, that he will dislike drinking and that he will avoid alcohol and often obeys these suggestions on recovering from the hypnotic state. But these methods do not have any effect on the basic problems and difficulties of the patient which have led to alcohol addiction.

The second group of therapeutic methods consists of substitute emotions. Many rakes have turned a corner after coming in contact with religious and social reformers who gave them a new outlet for the expression of their emotions. Religious conversion, seeking joy doing social service to the needy and the poor or joining social and political missions have deeply affected the personality of many alcohol addicts and induced them to seek satisfaction in activities other than drinking. A movement called Alcoholics Anonymous has gained considerable popularity and its programme



and approach is fundamentally different from routine temperance societies. It will be discussed in a separate section below.

The third group of psychotherapeutic methods aims at laying bare the basic and root causes of drinking. We have stressed many times in this chapter that people take to alcohol because it provides means of adjustment to urgent and stressful emotional and personal problems and difficulties. It is assumed that psychological treatment will bring out the real nature of such conflicts and difficulties, to strengthen the personality of the patient to resolve conflicts and meet difficulties in a realistic manner and thus to get rid of them. Once the patient is made to understand what the complexion of his conflicts is and how they can best be resolved he will not resort to such artificial means of adjustment such as the use of alcohol.

But how to make the patient understand this? It must be understood that everybody's conflicts are not the same and there are very large individual differences. Some will need careful and detailed interviews, others may have to be given long sessions of psychoanalytic treatment. We have already described in detail the several techniques of psychological treatment and the psychiatrist will employ one or more of them. The main general aim is to make the alcohol addict understand that his addiction is a very ineffective mode of adjustment to his problems and difficulties.

*Punishment* : In most countries the alcohol addicts if considered a public danger and a social risk are fined or sent to jail. But such punitive measures are of no avail considering that they do not at all touch the addict's problems and difficulties the real cause of alcoholism, and the person on release from jail or after paying the fine resumes his drinking. Parents and wives may also hold out threats that the drinker would be turned out of the family or disinherited if he touches liquor again. Such threats have only temporary effects and do not touch the basic cause of alcoholism.

*Drugs* : It is an ancient belief that some drugs can kill the craving for alcohol and it lingers even today. A number of patent drugs are sold in the market but most of them are quite harmless concoctions depending on suggestion for their efficacy or are themselves concoctions containing a high percentage of alcohol.



Before giving psychotherapy the patient has to be taken off alcohol completely. To help satisfactory result the patient is given what has come to be known the conditioned reflex method of treatment. The ancients used to give some nauseating thing along with wine so that the drinker was disgusted with wine and gave it up for good. This may also be called the aversion treatment by the use of the conditioned reflex. It consists of inducing nausea in the patient when he contemplates a drink. It is an abhorrent and disgusting procedure. The patient is kept in a plain room and every two hours he is given a powerful emetine injection which entering the blood stream causes nausea and vomiting. The time he takes to experience nausea after taking the injection is noted and just before he is expected to develop nausea he is offered his favourite wine. As he takes it the nausea starts and he vomits, and again he is offered wine and again he vomits. Two hours later the same process is repeated. After some repetitions drinking and wine are so strongly associated with nausea and vomiting that the very thought or sight of wine produces nausea and may incline him to vomit. During the course of this treatment psychotherapy should also be given so that the patient's aversion to liquor may be firmed up. Of course, it is always possible for the patient to overcome the conditioned reflex but the method of treatment helps the patient who is genuinely interested in getting rid of his addiction.

The drug tetraethyl thiuram disulphide (T.E.T.D.) when given just before drinking liquor produces distressing symptoms on taking liquor. It blocks the metabolism of alcohol and the drug increases the toxicity of alcohol and instead of feeling the usual glow and cheerfulness on taking liquor his face flushes and he becomes red, his eyes are distended and become bloodshot, the pulse rate increases, there is widespread throbbing and headache ; he feels alarmed, breathless ; sweating, nausea and vomiting make him very uncomfortable. After these reactions he falls asleep but the rigours of his experience remain fresh in his memory when he wakes. This drug is also known as disulfiram and the trade name is antabuse. Few patients will drink while taking this medicine. The knowledge that they cannot do so makes them reject this course of treatment and they say that they would like to follow their own method of treatment.



Another approach is to use stimulating drugs which practically produce the same effects as alcohol, a feeling of general well-being so that the use of liquor becomes unnecessary. Benzedrine is one such drug and has given encouraging results when used along with other forms of treatment.

### *Alcoholics Anonymous*

This wonderful movement was organized in the United States just before the Second World War and has not only increased its membership but extended its field of work outside that country. It was organized by alcoholics and its principles show an intimate knowledge of the plight of an alcoholic and of the pattern of his reactions. The group aims at helping other alcoholics to recover, it makes no monetary demands on the member and lays down no conditions on its membership—the alcoholic becomes a member from the very time the idea occurs to him. The Alcoholics Anonymous has no affiliations with other groups and offers nothing new but only a helpful mixture of old medical and religious principles and advice.

Once he attends a meeting the alcoholic is caught, and unless considerable damage has been done to his brain or he has passed the stage of redemption to enter into group activities he continues to attend. He meets other men who have either matched or surpassed his drinking and in the conversation which takes place there the general assumption is that if an alcoholic does not stop drinking he is sure to go mad or die. He comes across patients who have got over their drinking habit and are happy and look well fed and who just smile when he tries to defend or justify his drinking, completing his sentences for him when he fumbles. Even if he does not stop drinking just then the first meeting has a great impact on him and he begins to see that the arguments he used to defend or justify drinking are hollow and empty. To remain dry, the alcoholic is advised to follow twelve steps that Alcoholics Anonymous suggests. The organization does not insist that they cannot be violated but only that they are useful, but most members adopt them so that they may share the group life of the organization. The twelve steps are as follows :

1. We admit we were powerless over alcohol—that our lives had become unmanageable,

2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understand Him.
4. Made a searching and fearful moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. We are entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons whom we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them and others.
10. Continued to take personal inventory and when we were wrong admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps we tried to carry this message to other alcoholics and to practise these principles in all our affairs.

Alcoholics Anonymous offers fellowship, sympathy, help and a message of hope to alcoholics and invokes the power of God to help them overcome their shortcomings. These steps may appear strange to worldly people but they have worked better than the most scientific treatment. The alcoholic admits that his drinking is out of control and he can do so easily enough because his companions share this knowledge. He sees hope in the group, feels less anxious and becomes ready to embrace whatever creed is offered to him. Invoking the help of God helps him to overcome



the feeling of guilt and making amends to others adds to his self-respect. He also helps others.

This organization maintains cordial relations with the medical profession. Members who are ill are sent to doctors for treatment and yet it is formed because doctors have no cure for alcoholism.

The crux of the problem is that alcoholism is not one problem but many problems, and, therefore, there is not one method of treatment but many. The success of Alcoholics Anonymous is mainly due to the fact that they employ tried methods of psychotherapy like catharsis, conversion, massive group support and solid friendship. The Alcoholics Anonymous has been highly successful.

### QUESTIONS

1. Why do people drink? Discuss some of the theories regarding the drinking habit.
2. Distinguish between persons taking alcohol normally and alcohol addicts.
3. Describe the various types of alcoholic psychoses, giving their main symptoms.
4. Describe delirium tremens. What are its main symptoms and how can it be best treated?
5. Discuss some of the techniques in curing addicts to alcohol.
6. What do you know about Alcoholics Anonymous? Discuss their programme and approach.

## Epilepsy

Epilepsy is a conventional name for a group of disorders that agree in a single symptom only, namely, convulsive seizures, which are popularly called *fits*. Of all mental diseases epilepsy has the longest history in medical science. Very long ago it was called "the sacred disease" because it was believed to be the result of divine visitation. At some point in history it was attributed to evil spirits entering the brain. It is also known as *seizures* or the falling disease and there are several theories about its origin. Many famous names in history are known to have suffered from this disease, for example Julius Caesar, Charles V, Lord Byron, Napoleon, and the disease and its symptoms have been vividly described in several works of literature.

Epilepsy is of many types and is marked by a variety of sudden and recurring attacks of cerebral origin, by partial or complete loss of consciousness, with or without psychomotor disturbances. It is a recurring disturbance of consciousness accompanied by convulsive movements and of the autonomic nervous system. An epileptic attack varies in severity, it may be a minute disturbance of consciousness lasting a few moments or a wild fury. In fifty per cent patients the attack is preceded by a sort of warning called the *aura*. It may mean a discomfort in the abdomen or a slight dizziness. Such a warning lasts only a few seconds and does not give the patient time to prepare for it.

*Classification and symptoms*

There are numerous types of epilepsy but the patient may be classified as having *symptomatic* or *idiopathic epilepsy*. The former is due to some brain pathology or toxic condition, and the latter which is also called *essential* epilepsy refers to those cases which are not due to brain defect or toxic condition but to some inherited constitutional defect. Idiopathic epilepsy is twice as common as the symptomatic epilepsy.



For clinical purposes generally four types of epilepsy are recognized, viz., the *major* or the *grand mal*, the *minor* or the *petit mal*, the *psychic* or the *psychomotor epilepsy* and the *Jacksonian epilepsy*. Each of these forms may occur in either symptomatic or idiopathic cases, and the individual may give indication of one, two or more types. The Jacksonian type is limited to the symptomatic group. We shall also discuss the relation of epilepsy with hysteria as fits are common to both. Let us discuss these four types in detail.

*Major or the grand mal type:* Epileptic seizures involve spasmodic contraction of the skeletal muscles as their most conspicuous features. When the spasms are of the violent types in which the whole system of skeletal muscles is involved, we have the *major* or the *grand mal epilepsy*. It is marked by a very dramatic attack, and is the most prevalent type. Its outstanding characteristics are loss of consciousness and muscular convulsions of very acute type. There are three phases of the attack: there is the initial phase of warning called the *aura*, the *convulsion* or attack proper and the *post convulsive*. Before the warning signs appear there are quick changes in mood, disturbances in sensory functions and muscular tics. Some patients are very morose and irritable before the attacks, and some feel very much excited and happy before the attack.

The aura or warning of the coming attack of epilepsy is generally the same in any given individual so that the patient can know beforehand about the attack and may prepare for it. These warning signs take numerous forms in different individuals. Some of the common warning signs are impulsive running, changes in temperature, numbness of pain, choking sensation or feeling of strangeness. As already pointed out some people feel happy, others feel apprehensive and still others may have different emotional reactions. Hallucinations are fairly prevalent, usually of the visual type. Thus aura is a sensory or affective experience which warns him that he is going to have a seizure. If the aura were an invariable forerunner of a seizure, patients could be trained to protect themselves and even to prevent the seizure. Unfortunately not all patients have auras, and those who do cannot depend upon their occurrence before all seizures. Protection against dangers

which seizures may entail can be attained, however, by planning at other times. An epileptic driver may plan to draw up beside the road when a seizure is beginning and will find himself so parked when coming out of a convulsion. It might be supposed that an epileptic is in danger of having a seizure when crossing the street in traffic, but actually he will delay the seizure until he reaches safety.

The seizure proper comes on suddenly. The patient becomes altogether unconscious, he feels as if he were struck with a blow and stunned by an unseen hand, and he often falls down like a log of wood. His breathing is suspended. All his muscles become rigid, his jaws are clenched, his arms are extended and legs are outstretched. His posture on fall will depend on the nature and side of the fall. The general attack involves the chest, abdomen and larynx. He may cry out in pain though later he has no memory of it. His face becomes dark, then pale, and he may bite his tongue or lose control of it. This is called the *tonic* stage of the attack. The features are often contorted, the eyes may be open or closed and he does not react to light. This stage lasts about 30 seconds.

Then the air starts returning to the lungs and his movements become jerky. The rigid tonic stage is now passing into the *clonic* stage. Now his muscles have spasms instead of being rigid, and his head strikes the ground, his arms jerk repeatedly outward and his legs jerk up and down, his jaws open and close and there are bubbles of foam at his mouth. At first the movements are rapid but gradually they decrease in frequency. Urine and stools may pass out during this phase of the attack. Usually in about one to three minutes the convulsive movements slow down, the muscles gradually relax, and the patient begins to reach normalcy. Some persons recover consciousness immediately after the attack, others pass into deep sleep which is of varying duration from a few minutes to several hours.

The post-convulsive phase is of great psychological interest. Some regain clear consciousness and become normal, others complain of headaches and general listlessness, but some do not feel well. They are confused, bewildered and emotionally upset. When they are in this confused state, patients may impulsively engage in a number of activities, they may take off their clothes in public,



take a trip to strange places, steal or destroy things, attack innocent people standing by and commit some crime.

There may be several attacks a day or the interval between attacks may be as long as one year. Sometimes the second attack may occur before the patient has recovered from the first attack. This is called *status epilepticus*. In some individuals there is an attack of major or grand mal and it is followed by minor attacks of some other forms of epilepsy. Violent rage reactions occurring during the attack are called *epileptic furore*.

The interval between seizure to seizure varies with individuals and from period to period with the same individual. There may be several seizures in one day ; or they may be separated by days, weeks or months. The frequency of the seizure has no relation to its severity and the same individual may have grand mal and other minor epilepsies the same day. Sometimes in the interval between seizures the patient is normal, healthy and fit unless by brooding over his handicap or over the treatment he receives, he becomes neurotic. What is called an *epileptic personality* is a neurotic condition produced by the patient worrying about his trouble, by the shame he experiences in his social relations due to the seizure or by too much pampering attention he gets from his family. Patients of epilepsy who are admitted to hospitals frequently degenerate for these reasons.

Patients suffering from grand mal epilepsy frequently injure themselves by biting their tongues and burning or cutting themselves. If the patient is climbing stairs or lighting a fire he may injure himself severely.

Following a seizure of the grand mal type, and sometimes even after a seizure of the small petit mal type, the patient usually has *retrograde amnesia* for all that occurred during the attack. He does not remember anything about the events during the attack. This has led many people to think that during the attack the patient becomes unconscious but tests made on patients during the seizure have shown that they are conscious, though the field of attention is very much limited and his consciousness is very much confused.

*Petit mal*

These are minor attacks of epilepsy during which there is a temporary loss of consciousness that may range from a few seconds to minutes. It means "small illness". It would be more accurate to speak of diminution of consciousness rather than its loss. The patient stops doing the work in which he was engaged, looks vacantly in empty space or toward the floor—may be described as being absent from the job for that period of time, and then resumes his work. He may drop but generally he keeps his posture intact. If he was working with any tool, it may drop from his hand. Sometimes the seizure may be so short that the person is not even aware of it. Walking along he may suddenly stop in the middle of the road not knowing what has happened to him and the attack may be over before he is aware of it. His face grows pale and his looks are vacant. For months he may not suspect that he is having seizures. Sometimes these small seizures grow into severe attacks but this is not always the case. The best thing to do about a minor seizure is to ignore it completely, pay less attention to a small seizure, perhaps as much as you would give to a fit of coughing. When he recovers the people need not look at him with horror or give him too much attention. Even if it is discussed it should not be allowed to appear as if something very serious has happened. Such an attitude is most essential if the patient is to be helped.

*Psychomotor or psychic type.*

The principal feature of this type of seizure is psychic disturbance and this varies from one person to another. The symptoms are similar to those already described. There is loss of consciousness, but the activity in which he is engaged continues and the patient appears to be conscious. His movements, however, lose conscious direction and indicate how absent-minded the person has become. There are emotional outbursts and his actions are anti-social. Attacks may last a few seconds or they may continue for several days. If a person is typing he may go on typing the same line or if he is adding he may go on with the same column of figures. He may make many mistakes in his work. Mentally he is confused. There may be outbursts of rage or he may start



running like a mad man with no sense of direction or purpose. He may start throwing things out of his office or upset the dinner table. Occasionally in this type of epilepsy the patient may try to injure or kill himself or others. And later he has no memory of what he did during the seizure.

Psychic epilepsy is generally found in adults and males. Its reason is not known, but the number of patients with homicidal or suicidal reactions is very small.

### *Jacksonian epilepsy*

This type of epileptic seizure was first described by the neurologist Hughlings Jackson. It is a form of major or grand mal epilepsy. The convulsions are restricted to certain groups of muscles and start in one region of the body. One muscle twitches and there is numbness, tingling or burning in that region. There is no loss of consciousness and the patient is quite aware of the seizure and its progress. He is just a passive spectator of what is happening to him and he cannot do anything to help his condition. Gradually the spasms or convulsions spread to other parts of the body, particularly to that side which was originally affected. When this seizure spreads the patient loses consciousness. In most cases seizures end in generalized convulsions.

It is believed that in these seizures the attack originates in the brain centres associated with parts or muscles in which convulsions began or the first symptoms appeared. This means that in this type of epilepsy brain disturbance is involved. It is possible to remove the affected areas of the brain by surgery and thus restore the patient to health.

### *Deterioration in epilepsy*

After many years of disease a patient of epilepsy, even though treatment is continued, may deteriorate in mind and personality. This deterioration is progressive and psychotic reactions develop. It is held that such psychotic symptoms are the result of individual's own reactions to his disease. There is nothing inherent in epilepsy as such which may be considered responsible for such mental deterioration. In a study of epileptics who were admitted to a mental hospital it was found that only a very

few developed psychotic reactions. In such deterioration, memory is impaired and judgment is affected. Patients become extremely irritable and depressed with the passage of time and it is feared that they may injure themselves or injure people about them. They become extremely belligerent and may quarrel with other patients. And despite medical treatment their course is downhill.

### *Epilepsy and hysteria*

Both are marked by fits and may be confused. At one time hysterical fits resembled symptoms of grand mal type of epilepsy. Mass hysterical symptoms of the acute form have also been witnessed. It has been found that severe fits resembling those of epilepsy are the result of strong suggestion. But in hysteria the individual may cry, kick, roll about on the ground, pull his hair, beat his breast or bite and strike people standing by. These symptoms he takes on but he is careful not to injure himself unduly. His crying and laughing may be abnormal but he is quite conscious of himself and his activities, and there is a method in his madness and purpose in his fits. Most often these hystericals help him to defend himself or protect himself from certain stress situations which he normally cannot face. Epileptic fits are not purposive. Epileptic fits may occur at any hour of day or night, even when the person is asleep, but hysterical fits never occur in sleep. In epileptic seizures the eyes do not work and the patient takes no notice of light, and other bodily reflexes are disturbed, and in hysteria the eyes may be tightly closed but pupils dilate and the vision is quite normal.

In epilepsy the spasms leave the patient confused and bewildered, and he may pass into a stage of stupor, while in hysteria the patient feels fresh and relaxed after the fits.

The face of an epileptic during the seizure becomes pale or blue while the hysteria patient retains his normal colour. Hysterical fits generally follow an emotional disturbance or thwarting experience or some difficulties which he considers insurmountable, they are generally brought about in the presence of others and their onset is gradual. In fact unless somebody is looking hysterical fits do not occur and their duration varies with how people around react to it. Hysterical fits may



continue for hours. On the other hand epileptic fits come on all of a sudden and irrespective of the fact that anybody is looking or not. They may come at any time, even during sleep. Epileptic fits last only a few minutes, two or three minutes in fact, but fits of hysteria may last for hours. Hysterical fits depend mostly on psychological factors but in epilepsy the cause is biological or toxic.

### *Epilepsy and brain-waves*

One very specialized medical technique is used and referred to in the diagnosis of epilepsy. It is EEG, that is, electroencephalograms. The metabolic activities of the brain are accompanied by minute electrical charges or brain-waves and they are recorded by this technique. Some decades back, a great English neurologist Hughlings Jackson said that epilepsy denotes "occasional, sudden, excessive, rapid and local discharges of gray matter", and later investigations and development of techniques for recording minute electrical discharges from the brain tissue have practically confirmed Jackson's idea. A person sits or reclines on a sofa or bed so that his head does not shift position. Then electrodes are placed at different areas of the brain and tiny electrical currents are recorded on a moving paper. These brain-waves are referred to as occipital EEG, frontal EEG and so on. It has been definitely established that such brain-waves of an epileptic patient differ greatly in amplitude and frequency from those of a normal person. Normal persons have a fairly constant brain rhythm but the rhythms of epileptic patients are abnormally large and during the seizure these differences of rhythm are still more marked.

*Incidence :* On the basis of investigations carried on in the United States and Europe about four out of every 1,000 persons are epileptics. Of the new admissions to mental hospitals in the United States just two per cent are patients of epilepsy. It is estimated that only 10 per cent of the total number of people suffering from epilepsy are in hospitals. A good many patients of epilepsy are able to carry on their normal work and, therefore, the need of admitting them to mental hospitals arises only in the case of very severe cases. It has already been mentioned in



the beginning of this chapter that many great names in history were epileptics. It is only when there is great mental deterioration or the attacks are so severe that make the patient utterly incapable of any useful activity that patients are sent to hospitals.

No age is free from the seizures but they generally occur during early childhood and adolescence. Both sexes are involved but the individual differences in the duration and severity of the attacks are very large. Some have only a few attacks in their whole life, others have them fairly regularly.

### *Causal factors in epilepsy*

What factors biological and psychological predispose an individual to epilepsy? Numerous theories have been put forward regarding its causation and due to detailed investigations by numerous workers our ideas about the origin and rise of epilepsy have undergone considerable change. We may consider factors under two heads : biological and psychological.

*Biological factors :* Detailed studies of the family history of patients of epilepsy, and of twins indicate that epilepsy is an inherited disease. Mostly only those are afflicted with epilepsy whose parents and ancestors suffered from this disease. Those patients who were admitted to hospitals were closely studied in their ancestry and it was revealed that they had epilepsy in their family. Studies of twins have shown that if one of a pair suffered from epilepsy the other too had seizures. Epileptic patients have epileptic parents, brothers and sisters.

That epilepsy is due to some underlying organic brain condition is shown by the fact that distinctive brain-waves of pathological nature have been identified not only for epilepsy in general but also for its four types. But why these brain-waves are distinctive of epilepsy or what is their basis is not known. May be it is a case of multiple causation. But most of the investigators agree that this brain condition is hereditary. Thus family histories and electroencephalograms point to inheritance as an important factor in the etiology of epilepsy.

Hysterics often simulate epileptic seizures but the electroencephalogram decisively clinches the case.



This means that epilepsy has a physical basis. People prone to epileptic seizures inherit a nervous system whose functioning is defective. It may be intracranial pressure or other physiological cause. In grand mal variety of epilepsy organic brain defect is definitely indicated. A further proof of the fact that some epilepsy is definitely organic in origin is that epileptic seizures can be induced by injections of insulin and metrazol. Therefore, epilepsy remains primarily a neurological problem.

But the fact that hereditary factors are indicated in 60 to 80 per cent cases only inclines us to the view that some environmental factors may be precipitating the disease. Perhaps we would be more correct when we hold that individuals do not inherit seizures but only a disposition to them and it is the precipitating factors in the environment which complete the picture in making actual what was potential. In a family the first born is more prone to have seizures because he experiences greater shocks at birth. Such shocks as the baby receives at the time of delivery or when there are twins, and head injuries which he may sustain in later life may be responsible for seizures.

This raises the question of how far head injuries alone are sufficient to induce seizures. If it were so soldiers and other people receiving head injuries should develop epilepsy, but records show that a very small percentage of such soldiers develop epilepsy.

In one study an attempt has been made to show the relation of epileptic seizures to the effects of infection of such diseases as measles, meningitis, encephalitis or whooping cough. Kidney trouble or defective functioning of the endocrine system may also be responsible for seizures.

We have enumerated a number of biological factors which predispose an individual to epileptic seizures but their precise relation to the disease is obscured by a number of overlapping factors which is very natural.

*Psychological factors* : Psychological interpretation of epileptic seizures has been a subject of considerable speculation among psychologists. It is believed that in the case of essential or idiopathic epilepsy the psychological factors are of greater importance. Modern psychiatrists are veering round to the view that to



attribute epilepsy to heredity is to condemn it for all times to come as incurable and as preventing marriage and reproduction. It is probable that epileptic convulsions are another mechanism to reduce tension and diminish stress. The explosive discharge of the brain centres is associated with discharge of emotional tensions. In the epileptic seizures strongly dammed up emotions find an outlet. Such emotions are often highly aggressive and self-destructive and they may to some extent account for the destructive aspects of convulsions.

Some psychologists consider psychomotor epilepsy as a psychic equivalent of epileptic convulsions. They are tension-reducing activities even though they lead to abnormal behaviour. Mental conflicts and frustrations are known to predispose an individual to epilepsy. One proof of this truth is that epileptic convulsions can be induced in hypnotic state. Of course, some constitutional trend favouring epilepsy must be present already and frustration and conflict only help to aggravate it into an epileptic seizure.

Are there any specific personality traits which favour epileptic seizures? Studies made so far have not revealed any personality traits which may be associated with epileptic abnormal behaviour.

*Treatment* : When the epileptic seizure comes on little can be done to check or to help the patient. The short *petit mal* seizure is so short that it need not be attended to. When the major *grand mal* seizure comes on it is necessary to protect the patient from doing any injury to himself. A pillow may be inserted under his head so that he does not strike it against the hard ground ; a handkerchief need be stuffed into his mouth so that he does not bite his tongue which epileptics generally do. But this may not be always possible, particularly when the jaws are closed fast. The epileptic seizures are very frightful to watch but they are seldom fatal. What injuries the patient has are due to his fall or striking against some hard object. Medical men usually prescribe sedatives to calm down the epileptic but the effect is not favourable. When seizures are very frequent or very severe the best thing in the interest of both the patient and the family is that he should be lodged in a hospital. Unfortunately hospital facilities for



patients of epilepsy in India are very meagre. Care should be taken that they do not move about alone or drive a car by themselves so that if and when the seizure comes on there is somebody to help them.

To begin with the patient should be given a very thorough medical examination so that if there is any organic defect it may be treated. If epilepsy is of the idiopathic type, every effort should be made to treat him in a normal way without making any suggestion about his illness. Both the family and the patient should try to forget that he is suffering from epilepsy and should encourage him to undertake tasks of responsibility. Whatever risks are involved are less than the risk of making him develop neurotic troubles about his illness. Given competent advice as to how to conduct and protect himself when the seizure comes on the patient is likely to acquit himself very creditably in whatever task is given him within the range of his capacity. An epileptic is generally well prepared for emergencies and will do as well as others in any task. Some people are keen that an epileptic should not be allowed to drive a car but such drivers are more careful than others and if well-guided usually park their cars on one side of the road when the attack comes on.

Usually parents withdraw epileptic students from the school or the college fearing that they may come to harm all of a sudden when the seizure comes on, but such a step is very bad for the patient. Giving up responsibility is a serious step downward. People around, students and teachers, should be taught to adopt a very casual attitude to the epileptic student so that he has no psychological difficulty in his work and his environment. There is remedy for idiopathic epilepsy but we can give the patient a fighting chance by making his environments as favourable as possible.

The treatment of grand mal epilepsy with the help of drugs has paved the way for search for better medicines. Early in the present century phenobarbital was used with some success. Later dilantin was discovered. The use of this drug reduces both the severity and number of seizures in nearly 30 per cent of the cases. Recently many new drugs have come into being, parti-



cularly useful has been mesantoin. But these drugs have no effect in *petit mal* epilepsy. For this type the drug tridione has been found very effective. One-third of the cases found relief and in the other two-thirds the seizures were less severe.

The patient should be made as comfortable as possible and given a very nourishing diet in which there is no starch but is rich in fat. His life should be carefully regulated so that he has enough to do, plenty of rest and meals at regular hours. His work should be light and interesting. Some people believe that he should be given as little water as possible. Others advocate electro-shock treatment. All these have their advantages.

For psychological aspects psychotherapy is likely to be useful. It is recommended that psychological treatment should go side by side with other forms of treatment. It will help to build up in patients strong defence against the seizures. We have not only to treat the ailment but also the patient, his personality and mental make-up. An epileptic is usually a very morose, depressed and irritable person. He is very sensitive and indifferent to people and things around him. These traits of personality are not the cause but the effect of epilepsy. His lot is a difficult one. He is unable to participate in group life as much as he would like, others shun and avoid him. He is rejected at one time and pampered at another. With nothing to do and with ever-present fear of the seizure he is bound to react unfavourably to his life and situation. The most important and foremost thing to do is to make him accept his lot and admit his ailment frankly. Attempts to hide and conceal his trouble will only add to his difficulties. As has been stressed above people around him at home or outside should not bring up the subject of his illness in talking to him and should treat him casually as they treat normal people. If the patient leads a normal life engaging in normal activities and assuming responsibility for tasks which are well within his range, if he is encouraged and helped to accomplish things, and if people do not shun him, he will retain his normal approach to things and people and develop happy adjustments to his world. In some countries special workshops have been started for epileptics and there they get experience of accomplishment and success and



acquire self-esteem. This is very conducive to the mental health of a person.

Intelligence tests have revealed that the IQ of epileptic persons is generally lower by 10 to 15 points than the average. In general patients of idiopathic epilepsy are brighter than those of symptomatic epilepsy. There are several reasons for it. Convulsions are after all a disturbance of the cerebral cortex and such disturbances are sure to interfere with the intellectual development of the individual. Secondly, epilepsy has a deteriorating effect on mind including intelligence. Thirdly, this retardation in intellectual activity may also be due to lack of opportunities for regular education. If convulsions start in early childhood schooling is definitely interfered with and development of intellect is retarded. Persons with a history of seizures show greater retardation. If and when these seizures grow less severe and decrease in number the individual shows improvement in IQ.

A good many epileptic patients are mentally deficient. The percentage of mental deficiency among epileptics is higher than that of general population. This percentage is highest among idiots.

Mention has already been made of how personality deteriorates in all aspects with prolonged duration of the disease. The epileptic lives and moves in a small world of things and persons. He loses interest in people around him, in his personal appearance and welfare, and in events which take place in his environment. He has no initiative, no enthusiasm ; he does not think and he feels very indifferent ; and his health is very weak and his movements are slow. He wears a pale and vacant look. The importance of psychotherapy and nourishing diet and careful nursing, therefore, cannot be over-rated.

### *Education of the epileptic*

If the seizures are frequent and very severe, and if the IQ is low there is hardly any question of sending the child to regular school. In severe cases consciousness is confused and the patient may have anti-social trends. So he cannot profit by school instruction nor participate in the group life of the school. But those cases in which seizures are less severe and frequent may be taught

at home or in special schools or classes. Milder cases may be sent to school but both the teacher and students should be well-informed about the illness of the child so that they may help him if necessary.\* They should also be advised to have a casual attitude toward the epileptic child so that he is not made to suffer any ridicule or humiliation nor is made to feel too self-conscious about his trouble.

### *Should epileptics marry?*

In India everybody marries and many parents by hook or crook get their epileptic children married. Often the future wife or husband is not told about the illness of his or her partner. Trouble follows. Then it is the religious duty of every married person to beget children, a son is very much coveted. Educated parents may feel that they would be passing on their trouble to children but uneducated parents have no such pangs of conscience. And the chances of adding to the affliction of the next generation are greater. Some sort of a medical fitness certificate is necessary before permitting young people to enter matrimony.

## QUESTIONS

1. Give a general description of a person afflicted with epilepsy.
2. What are the symptoms of epilepsy? Describe some of its important types and their symptoms.
3. What are the main causes of the origin of epilepsy? Discuss the role of heredity and environment in epilepsy.
4. What would you do if you had a member of your family suffering from epilepsy?
5. Describe some of the important techniques of treatment in epilepsy.
6. What do you understand by Grand Mal, Petit Mal, Psychic equivalents, Jacksonian epilepsy and brain-waves?



## Mental Deficiency

Mental deficiency or feeble-mindedness means marked limitation of intelligence, due to retarded development, which results in social and economic incompetence. Whatever the culture and whatever the stratum of society a mentally deficient person is not able to manage his own affairs, to solve his own problems, to earn a living, to benefit by school teaching or to enter into healthy mature relations with other members of society. He has little commonsense, prudence or insight into ordinary affairs of life. His intellectual growth and development is retarded and he is not able to conduct himself as normal individuals do. So in this sense a mentally deficient or feeble-minded person is abnormal.

Mental deficiency should not be confused with mental deterioration or mental disease. It certainly is not insanity. A mentally deficient individual has less capacity or ability, his defect is in mental or intellectual equipment. He does not have the same degree of ability as other normal individuals possess. In mental deterioration there is loss of efficiency or ability due to some injury, disease or poison. The individual had the ability but he has lost it, but a mentally defective person never possessed it.

Mental deficiency cannot be detected from outward appearance. It is only when persons are engaged in a task which challenges their intelligence and in which they are called upon to solve a problem or to learn new things that intellectual shortcomings are revealed.

Mental deficiency or feeble-mindedness is also known as *amentia* or *oligophrenia*.

### *Diagnosis of mental deficiency*

As a result of the remarkable growth and development of the mental testing movement in our own century we are able not only to distinguish the feeble-minded or mentally deficient children from others but also to measure the degree and level of such feeble-mindedness. Binet and Simon developed the first scale of

intelligence tests and later Terman, Hollingworth and Goddard perfected further the tools of intelligence testing. On the basis of these tests each individual is found to have an Intelligence Quotient or I.Q. which is a measure of brightness obtained by dividing the mental age of that individual by his chronological age. The I.Q. indicates the rate of his growth. If tests indicate that his mental age is 8 while his chronological age is 9, his growth is less. If his age is 7 his growth is faster. Two children having a mental age of 8, one whose actual age is 7 is brighter and one whose actual age is 9 is slower. A child whose mental age and actual age is the same is normal and his I.Q. would be 100. Those whose I.Q. is above 100 are of superior intelligence and those whose I.Q. is below 100 are of inferior intelligence.

Terman found that intelligence of the American population was roughly distributed as follows.

I.Q.	Class	Approximate percentage of population
150 and above	Near genius	.2
130 149	Very superior	3.0
115 129	Superior	14.0
85 114	Normal	66.0
70 84	Dull	14.0
50 69	Moron	
20 49	Imbecile      Defective	3.0
Below 20	Idiot	

Of course no hard and fast line can be drawn between these classes. No real difference can be noted between I.Q.s 114 and 115 or those having 69 and 70. Psychologists are today agreed about three grades of mental deficiencies, moron, imbecile and idiots.

But what are the marks of a mental defective? For one thing his I.Q. is below 70, but how does his I.Q. affect his behaviour? The answer to this question will depend on what view we take of intelligence. Intelligence today is considered a complex inherited ability by which a person learns new things, acquires useful knowledge and skills, makes effective and efficient adjustments to his environment, adapts himself to the changing conditions in his environment, profits from his past experience, engages in abstract



and constructive thinking, uses critical judgment, reviews his mistakes and errors to understand them and avoid them in future, and has a reasonable insight as to how his problems, difficulties and life situations are going to turn out in future. An intelligent person's behaviour is marked by all these attributes. He learns easily and quickly, he has clear impressions and sizes up situations clearly, his understanding assimilates and retains better, he manipulates ideas actively and with a definite purpose, he is sensitive and responsive to minute details and differences in the conditions around him. He is open-minded and tries out one idea after another. He is able to judge whether he has succeeded in the task assigned to him. He has self-confidence and criticizes his own performance. His motives, wishes and purposes are strong. Now a mentally deficient person does not have all this. He is slow to learn and what he learns is not effective. His understanding, thinking, retention, and judgment are poor. All those who have had feeble-minded children in their class and home know how difficult and tedious it is to make them learn and acquire anything. The key to learning is the ability to retain and this is not so high in the feeble-minded.

We have described how intelligent quotients rise and fall. This means that the difference between the different classes mentioned is one of degree rather than kind. The superior have more intelligence than the average and the inferior or feeble-minded have less intelligence than the average. Thus the absence of intelligence is relative rather than absolute.

From the above table readers must have known how intelligence is distributed in the general population. The average is in a vast majority showing that God must have loved the common individual because he made so many of them, and the number of superior persons is matched by the number of inferior persons. Women have not produced many geniuses nor have they burdened society with many mentally deficient.

Not only are the mentally deficient people less intelligent, they are also not socially adequate. They cannot look after themselves so well, they cannot manage their own affairs, and they cannot support themselves. They require extra help from others for these purposes. They have to be fed and dressed, carefully protected

from danger, accidents and pitfalls, their games have to be supervised. Their level is much lower than their age in almost every aspect of life. That is why they are always inclined to mix with people much younger than themselves. When they grow up they are dependent on others. Their self-control is low.

Their drives and motives are not strong, and they do not persist in what they undertake. Their feelings and emotions are simple and primitive. They may feel anger, joy and fear but they have no feelings of honour, duty or decency. They have no finer feelings and as such they have no charm, subtlety or even meanness in their personality.

The feeble-minded are slow to develop even physically. They learn to walk and talk much later than average children. Their motor efficiency is not of high order, their gait is not very regular, and their speech is also often defective. Their sensory discrimination is less acute and defects of seeing and hearing are common at all levels. Their physical appearance also may not be attractive and they usually have anatomical defects.

### *Morons, imbeciles, and idiots*

We have already seen that mental deficiency has grades and among mental defectives morons are the highest in I.Q. The term "moron" was coined by the American psychologist Goddard to specify the highest level of mental defect, ranging in I.Q. from 50 to 70. An adult moron has a mental age of 8 to 10 or 11 years. The men can be taught to do many kinds of farm work, carpentry, chair-caning, work of a janitor and even mechanical jobs like operating a lathe. Women morons can be taught to knit, cook, wait on tables, do fancy laundry and work on a washing machine. But morons have to be guided and supervised; they are at a loss when anything goes wrong. They get along best when working on a farm or living in a small town, where they are known to everybody and where allowances are made for their dullness and consequent shortcomings. In large cities life is difficult for morons, some of them drift into thievery, prostitution and other petty crimes.

If carefully handled morons can be taught to read and write



and do simple arithmetic. Their scholastic achievements seldom go higher than fourth class. They can learn to support themselves. But even self-supporting morons are incapable of making suitable social adjustments. If they are not guided and supervised they may spend what they earn quite foolishly. They are incapable of looking ahead and planning for the future.

Imbeciles lie in between the morons and the idiots. Their I.Q. ranges between 25 and 50 and an adult imbecile has a mental age equivalent to that of a child between 4 and 7 years. They can learn how to look after themselves for very simple needs like dressing, washing and feeding themselves. They can do many kinds of routine work, such as washing floors, digging holes, weeding, dish-washing, simple sewing and laundry work. What they will do has to be planned by others and their work has to be supervised at every step. Even the brightest of imbeciles when most carefully taught will seldom reach beyond the first primary class. They seldom learn to read. They are incapable of earning a living.

Idiots are the worst-off group and their lot is pretty hopeless. Having an I.Q. below 25 and mental age of 3 years or less, they have to be treated like infants. They have to be carefully looked after and require help to eat, dress, wash, and must be protected against common physical dangers. After long training some idiots can be taught to dress and undress themselves. But they never learn to speak and understand more than a very few words. Sensory handicaps and motor defects are common in this group, and their physical resistance to disease is very low. They have many physiological anomalies and readily fall a prey to disease.

Both idiots and imbeciles need to be kept in special institutions but in India one may ask where are they?

Mental defectives constitute only 3 per cent of the general population. Out of every 100 mentally deficient persons 75 are morons, 19 are imbeciles and 6 are idiots. Percentages of these classes for admissions to hospitals in the United States are different. For every 100 feeble-minded persons admitted 15 are idiots, 30 are imbeciles, 45 are morons and the rest are unidentified.

#### *Idiots savants*

Once in a while a mentally deficient person gives evidence



of possessing exceptional talents or skill in some special line and they are called "idiots savants". Such a description is mistaken for they are imbeciles and not idiots and they are savants only by courtesy. Their special skill is generally in the field of memory, mathematics or mechanical ability. Such a skill may be of no practical value. This condition is very rare and the cases reported are not very many. It may be partly due to the fact that our field of observation too has been limited.

In institutions meant for mentally deficient persons one or two are found now and then who are very good in drawing, music or have good memory for finding out days of dates in different months of any year. The latter performance is rather dramatic and attempts have been made to find out the process by which such days were found or calculated. The mentally defective person could not give any clear reply. His performance applied to future dates also. A. F. Tredgold a well-known British authority on feeble-mindedness records the case of the "Genius of Earlswood Asylum". The person was an inmate of the Earlswood Asylum from 1850 to 1916, Pullen by name. Pullen astonished the authorities by producing remarkable crayon drawings, carving expertly on ivory and wood and constructing ship models so intricate and detailed that they are still displayed in the two large work-rooms placed at the disposal of the asylum. His proudest accomplishment was ten-foot model steamship that took more than three years to complete. It is equipped with brass anchors, screws, pulley blocks, copper paddles, 5,585 copper rivets, and 13 complete life-boats. It also contains nearly a million and a quarter wooden pins fixing the planks to the ribs. Pullen made these with a special instrument of his own designing. The cabins were decorated and furnished with chairs, tables, beds and bunks.

But in other abilities Pullen was deficient. Until the age of 7 he could not speak and then for a long time uttered only the word "muvver". He learned to dress and wash himself and eventually to write the names of simple objects, but this was all he could do. He was deaf, but behaved well at the asylum and if left alone would keep himself busy. A crisis came into his life when he fell in love and determined to marry the lady against all arguments. But the committee to detract his attention presented him with the



gold braided uniform suggesting that if he gave up the idea of marriage he would be made an admiral of the navy. Pullen fell with the plan and never again mentioned marriage. He died at the age of 81 having worn the uniform on several occasions.

Tredgold observes that Pullen was emotionally childish, unstable and unbalanced but he had good observation, attention and memory. The special talents of the so-called idiots savants is a mystery and nothing is known about their etiology.

*Classification :* Mental deficiency is of many kinds but the classifications proposed by Tredgold and Lewis are very significant and we may consider them in detail. These types are of independent origin and have their distinct symptoms.

*Primary-secondary :* In former times it was held that feeble-mindedness or mental deficiency was simply a matter of heredity. Tredgold distinguished two types of amentia or mental deficiency and these he called *primary* and *secondary*. Primary mental deficiency is due to heredity and secondary mental deficiency is due to organic brain defect due to some factors operating after conception. There may be number of mental defectives in whom mental deficiency due to heredity and some illness or injury is also involved. This means that both primary and secondary types of mental deficiency may be present in the same individual. It is common that hereditary mental deficiency is accompanied by some disturbance of the endocrine glands, disease or brain injury.

In primary mental deficiency there is a history of parents, grandparents and siblings being mentally deficient. This type of mental deficiency is transmitted through the genes according to the laws of inheritance. Some people believe all mental deficiency to be of the primary type, others believe it to be as high as 85 per cent, and still others place it at 40 per cent.

Secondary amentia is in a sense acquired by adverse outside factors after conception. At the time of conception the child may have perfectly normal brain but he may receive certain injuries in the brain before or at the time of birth producing severe mental defects. It is estimated that 20 per cent of all mental

defectives belong to this category. Some ten per cent owe their misfortune to infections which cause lesions in the brain, half of that number became defective because of some shock received from injury and two to three per cent owe their trouble to defective functioning of the endocrine system of glands.

This classification may appear to be very rational but in actual practice it may not be possible to distinguish between the two types, whether a particular individual owes his or her mental deficiency to heredity or external factors. As has already been stressed there may be considerable over-lapping. Nor is it possible to identify the exact nature of the external factors.

All degrees of mental deficiency described above are found in both primary and secondary types of amentia. The important thing to remember is that in secondary type of mental deficiency there is no family history of this abnormality among parents or grandparents.

According to Lewis mental defectives can be grouped under two heads, *sub-cultural* and *pathological*. Most mentally deficient patients belong to the sub-cultural group. They differ from the average normal persons only in degree and not in kind, their I.Q. is lower and quantitatively they are placed at the lowest end of the series of intelligent people, just as short people are placed in relation to tall people at the lowest rung of the ladder. Pathological group of mentally deficient people do not stand at the lowest end. They are qualitatively different from the normal people and their mental make-up is of a different order altogether. Even with regard to physique the pathological group represents a different group from the general population. The sub-cultural group will be of the same type only shorter and smaller but the pathological group will have constitutional and anatomical abnormalities. As in the above classification all degrees of feeble-mindedness may be found in either type but the sub-cultural group represents the brighter section of aments. The sub-cultural group is generally found in poorer classes of society whose socio-economic status is much lower than that of the general population. Heredity is the main factor in this group but pathological type is due to organic defect or injury.



*Causes and predisposing factors*

Feeble-mindedness is a case of multiple causation and most of the mentally deficient people are the result of a number of factors working together. Studies of family histories and twins reveal that heredity is the main causal factor. A large percentage of feeble-minded people come from families which have a history of mental deficiency. That one twin should be feeble-minded and the other intelligent is very uncommon. Several studies show that both twins are generally found to be mentally deficient.

Other factors include physical injury to the brain, damage of the brain tissue due to infection, disturbance of the functioning of the endocrine glands system, epilepsy and other physiological disturbances. There is a widespread prejudice that alcoholics and other drug addicts have feeble-minded children. This is not true. The intelligence of children is determined by the intelligence of parents and not by their habits, but alcoholics or drug addicts whose intellectual development was retarded may beget feeble-minded children.

Another widespread belief among Hindus is that consanguinity leads to mental deficiency. Not only marriage between cousins is forbidden but it is banned even between young people of the same *gotra* or sub-caste. Recently due to spread of western education and ideas some marriages between people of the same sub-caste have taken place but they are not approved by society. But what studies have been made indicate that unless there is some trace of feeble-mindedness in the two families such fears are not well founded. If such traces are present they will be concentrated and the likelihood of children becoming mentally deficient will be increased.

Socio-economic status may account for some mental deficiency. Though aments are found in all sections of society they seem to be in large number in slums and backward classes. It suggests that socio-economic status of the family is to some extent responsible for mental deficiency. This is more true in the cases of morons. Idiots and imbeciles are found in all sections of society and at all socio-economic levels.

*Clinical types of mental deficiency*

Most of the clinical types of mental defectives are found to belong to the secondary type of amentia. Such deficiencies develop after fertilization as a result of injury, disease or disturbance of the glandular function. Let us describe their types.

The first is the *simple* type in which no distinguishing characteristics are present. Such feeble-minded persons look very much like the common normal people. But in a general way they are not so attractive, do not have the normal stature and have a number of physical defects. Studies of their brains reveal no special abnormalities. Such simple feeble-mindedness is aggravated by lack of education and unfavourable social environment, but its basic cause is heredity. Their parents must have been feeble-minded and generally belonged to the class of unskilled labourers. Even if their parents were not so defective mentally they must have carried the strain of feeble-mindedness to beget feeble-minded children. Mentally deficient children are not alone in any family.

*Mongolism of Mongolian amentia*: Individuals belonging to this type strongly resemble in physical features the Mongolian race. Hence this name is given to them. They represent one of the most peculiar growth disorders. Anomalies of physical features are found in the skull, the eyes, and the tongue. The skull is small and rounded, and front and back of the head are small and flat. The eyes are almond-shaped and slanting with the skin of the eyelids abnormally thick and the distance between the eyes specially narrow. The lips are thin and fissured and dry and the tongue is usually large and flabby. The nose is flat and short with a lower bridge, the hands are stubby and flabby, ears are of unusually large size, the tongue is usually large, the joints are loose and the hairs are dry and wiry. The stature is short and the mongloid usually under-weight. The voice is deep and helps the diagnosis.

The mongloids suffer mostly from respiratory, circulatory and gastrointestinal diseases and they are usually short-lived.

These children are mostly of the imbecile level of mental development and their intelligence quotient ranges from 50 to 20. They very rarely reach a mental standard beyond that of the



age of a five-year old. But it is possible for them to learn many things by imitation particularly the manual tasks. They are good mimics and may do whatever the adults around them do. They usually get great pleasure in doing and saying what others say and do. They are very tender and affectionate and usually earn the goodwill and affection of people around them. They are quite lively and bright but whatever the impression their affectionate mimicry may inspire it should not be forgotten that they are sub-normal in mental development and their I.Q. is lower than that of morons. Two-thirds of them are imbeciles and the rest are idiots. They die young and few of them live after attaining the age of ten. They are unable to speak and whatever words they learn come very late.

Mongolism is found in all sections of society irrespective of their socio-economic status. They are born to rich and intelligent parents, as often as they are born to poor and backward parents, and they are found in all parts of the world and in all races. They are only 5 per cent of the total number of mental defectives. This is partly due to the fact that they die early.

By tradition the cause of mongolism was taken to be faulty heredity to which were occasionally added other factors like syphilis, vitamin deficiency, parental alcoholism, disturbance of the glandular function, the use of contraceptives, exhaustion of the mother due to a number of pregnancies in quick succession, injuries during pregnancy or incomplete development in the womb. Recent studies in the United States discount the factor of heredity. In one study it is shown that mongolism does not occur more than once in a family and, therefore, heredity is probably not a factor. If heredity were an important factor more than one mongloid child would be frequently found. Another view is that mongolism is probably due to damage done to germ plasm. It is a germinal disorder. A third view is that the mother's condition was pathological in the beginning of pregnancy. One study records that mothers of mongloids are considerably older than mothers of normal children. Bleyer found that of 2,822 cases examined more than 50 per cent mothers were older than 35 when their mongloid child was born. But since mongloids are also born to younger mothers it cannot be held to be a very important factor,



and, of course, many older mothers give birth to normal children. To counteract the argument that mothers exhausted by frequent child-bearing give birth to mongloids it may be pointed out that many mothers of mongloid children have later on given birth to normal children. Perhaps what disturbances occurred during pregnancy of the mongloid child did not occur later on. If uterine disturbances and exhaustion were important factors both twins would have been mongloids but it is found that if the twins are both mongloids they are always of the same sex but if they are of different sexes, that is if one of them is male and the other female, then only one of them is mongloid. This very much supports the theory of heredity.

*Microcephaly or Microcephalic amentia*: The distinguishing feature of this clinical condition is very small circumference of the skull, averaging about 17 inches. The microcephalics are called "pin heads" and in India too they have funny names in every language. The cranium fails to develop to full normal size and there is consequent defective development of cerebral cortex. Tredgold holds that the shape of the skull is more important in the diagnosis of this clinical type than the size of the skull. The back of the skull is flat and the skull is cone-shaped and the frontal region is pushed back. The chin too shows this recession. Under the circumstances the brain capacity must be quite deficient. The brain of one individual weighed only 170 grams against the average weight of 1,374 grams. Besides this characteristic of shape and size of the skull these patients are of very short stature. Very few of them ever attain a height greater than five feet. Intellectually microcephalics fall in the group of idiots and imbeciles. While their motor development is good their development in language is extremely poor and their capacity for mental work is very much limited. They are very genial people to live with, their emotions are uninhibited, they are very restless and active. Some of them rise to the levels of morons.

Less than one per cent of the mentally deficient people are of this type.

The exact condition which leads to this disorder is not very clearly known. In one study it was revealed that mothers who were subjected to X-ray treatment during pregnancy in 25 per cent cases



give birth to microcephalics. Another study stresses arrested development in the fourth or fifth month of the fetal period. Tredgold holds that the condition is due to defective inheritance and, therefore, he places it among disorders known as primary amentia. No remedy for this pathological condition has yet been discovered.

*Hydrocephalus or Hydrocephalic amentia*: The distinguishing feature of this disorder is extremely large skull. The abnormally large skull is the result of over-accumulation of the cerebrospinal fluid, which may amount to several pints. This accumulation is the result of some obstruction in the path of circulation or insufficient absorption. *Hydrocephalus* is the term from the large cranium which results, from this over-accumulation of the fluid. In some cases the circumference of the skull may be as large as 30 inches.

This accumulation of the fluid exerts pressure on the brain tissue adjacent to the ventricles and they either become very thin or are destroyed resulting in enfeeblement and under-development of the brain. It is obvious that there will be degrees of hydrocephalus depending on the amount of accumulation of fluid. If this accumulation is small there will be less damage and if it is too large the patient may die. Most of the cases of hydrocephalus belong to the imbecile and moron levels. In cases where the condition is acute so that the patient is of the level of an idiot death follows soon. Emotionally the hydrocephalics are usually cheerful, affectionate and genial in temper.

No satisfactory treatment of this disorder is known. Attempts have been made to reduce the amount of liquid accumulated by draining it through surgical techniques, and if these techniques are tried fairly early results are satisfactory. Sometimes tiny valves artificially made by surgery allow free drainage of the fluid, but the results are not very encouraging.

*Cretinism*: A typical cretin has a dwarflike appearance, thick-set body and short, stubby extremities. When standing, his height is a little over three feet. His shortness looks bad because his legs are slightly bent. He shuffles when he walks and can be easily recognized. His head is large, with abundant black wiry hair; his eyelids are thick giving him a sleepy appearance. His skin is dry

and thick and hangs in folds. The mouth is half-opened by too large a tongue and is made still more ugly by thick lips. There is no lustre in his eyes. He has a flat nose, a flabby body, protruding abdomen, and lack of sexual maturity.

Cretins are an example of mental deficiency resulting from endocrine imbalance, the thyroid gland has either failed to develop properly or has undergone degeneration or injury, and the person suffers from a deficiency of thyroxine secretion. Cretinism is very common in those areas of the world where there is no or little iodine in drinking water and soil and consequently in the foods which grow there. Pregnant mothers do not get enough iodine and give birth to children with defective thyroids. Thyroid deficiency leads to mental deficiency. In those areas cretinism is found in every generation and this gave the impression that it could be hereditary.

If the condition is recognized early and the extract of thyroid glands is given, there is a good prospect for the child to grow and develop both physically and mentally in a normal manner. There are many cases of children restored to normal personality level by thyroxine treatment. The success of the treatment depends on how early the deficiency is detected and the degree and duration of thyroid deficiency. If the treatment is delayed or the deficiency is too acute the damage done to the nervous system is beyond treatment. Several public health measures have been taken in large towns and in those areas where there is lack of iodine in water and soil by asking people to use iodized salt.

About one per cent of the cases of mental deficiency admitted to mental hospitals are due to cretinism.

*Unclassified mental deficiencies* : It must have become clear to the readers that these definite types of mental deficiencies account for only a small percentage of feeble-minded people and a large number of cases of mental deficiency do not belong to any of these types. Such cases are described under unclassified mental deficiencies. They are due mostly to pre-natal factors and complications arising in the course of pregnancy. Such complications are varied and numerous and retard growth and impair mental functions for example disturbances and complications arising in premature delivery and infectious diseases which affect the placenta or are



transmitted through it to the fetus. Typhoid fever, scarlet fever, pneumonia, measles, malaria and syphilis may affect the fetus during pregnancy. Of these syphilis contributes the largest number of mentally deficient children.

*Congenital syphilis* accounts for some cases of mental deficiency. Children of mothers suffering from syphilis are sometimes infected with the disease while still in the uterus. "Some of them are born dead and some are victims of abortion. Those who survive may be normal or suffer from mental deficiency. It is estimated that 5 per cent of mental deficiency is due to inborn syphilis. Most of these mental defectives are either idiots or imbeciles. Such victims frequently suffer from some physical handicap like paralysis of limbs, epilepsy, blindness or deafness along with muteness. Even those infected children who show normal mental growth later on develop paresis. There is no satisfactory treatment and no hope of recovery.

*Amauratic family idiocy* is a rare form of mental deficiency. Hardly 1 out of 500 of the mental defectives admitted to mental hospitals are found suffering from it. It is also known as *Tay Sach's disease*. This disorder is mostly neurological marked by increasing degeneration of the brain leading to blindness, wasting of limbs and growing deficiency of intellectual functioning. Its cause is heredity and is transmitted through defective genes. This disease is very common among Jewish children.

*Sclerotic amentia* is marked by an overgrowth of neuralgia which supports the nervous part of the brain. The skull is enlarged, but the shape of the head and the skull is different from the patient of hydrocephaly.

#### *Mental deficiency due to birth trauma*

It is not fully realized that every infant born has to pass through a shocking experience and injuries during birth account for 5 to 10 per cent of mentally deficient cases. Haemorrhage during the period of labour of the mother produces lesions in the brain and lead to amentia. Such haemorrhage occurs frequently when birth is very difficult and the infant is born prematurely. Delivery is not always easy and any accidental injury may affect the brain of the new-born.

Another cause is asphyxis or suffocation due to lack of oxygen. During birth, at any stage, the infant may be suffocated for some time causing damage to the brain and consequent impairment of mental functions. Or the breathing of the new-born may be delayed due to a large variety of causes.

Brain damage may occur due to a large variety of causes working at birth or even after it and may produce mental deficiency.

#### *Mental deficiency due to after-birth factors*

In early infancy life for the child is difficult and he is very susceptible to infection and even a slight injury may cause havoc to his brain. Various types of head injuries may affect the brain and cause amentia. Common diseases of children like measles, mumps, chicken pox and others may cause serious damage to the brain and produce mental deficiency. A disease like meningitis raging in an epidemic form may cause damage to children's brain and in one study it is estimated that 2 per cent of the cases of mental deficiency admitted to mental hospitals are the result of brain damage by this disease.

#### *Feeble-mindedness and abnormal behaviour*

Most feeble-minded people young and old are often found to behave in a manner which is not permitted by law and is anti-social or which is abnormal in some other sense. We will discuss here the relation of feeble-mindedness to delinquency and crime and if there is any psychotic behaviour associated with mental deficiency.

Popular prejudice associates delinquency and crime with mental deficiency but most authorities discount that crime and delinquency are more common among mental defectives than the general population. In interpreting the greater prevalence or frequency of crime among mental defectives a number of factors must be considered. In the first place most of the mental defectives involved in crime do not fully comprehend the implications of law and social welfare. Allowance must be made for their poor understanding and intelligence. Legal sense is a moral sense which ultimately depends on how well social welfare and moral law is understood and appreciated. Secondly, and this is a most crucial



point, because of poor intelligence mental defectives are more easily caught in any criminal activity than an intelligent, clever person or even a person of average intelligence. If our figures are based on the number of persons apprehended for crime we must make allowances for the fact that a mentally defective person is more easily caught than one of average or superior intelligence. Thirdly most of the mental defectives come from poor illiterate and backward families living in slums and when their parents and other relations have no social or moral sense they should not be expected to have any. Though through public agitation western countries have been obliged to put these crime-inclined mental defectives in institutions to save and protect society from their anti-social activities, and even though the number of mental defectives in penal institutions is much larger psychologists and sociologists are not inclined to accept the prejudice that feeble-minded people are naturally more inclined to crime than the general population. Rather they have demonstrated that mental deficiency is neither the cause nor an important factor in crime. In fact it is not mental deficiency by itself which causes criminal behaviour but the lack of social and personal adjustments inherent in mental deficiency which lands the feeble-minded in criminal behaviour. There is no doubt that mental defectives are not readily able to foresee the consequences of what they do. A good many are not detected in life and because they are borderline cases nobody sees that they are mentally defective. And then they may be called upon to do jobs for which they are not mentally equipped. This may result in behaviour which is not strictly in accordance with the demands of social welfare and happiness. Thus it would not be fair to indulge in a sweeping observation that feeble-minded people are more prone to crime.

But though mental deficiency is not the cause of crime there are certain types of anti-social behaviour which are very prevalent among the mentally defective. One investigator has found that minor offences like stealing, truancy or mild sex-offences are common among the feeble-minded. Sex offences are most frequent among young girls who are mentally defective.

Even criminal behaviour needs intelligent planning and execution and since the mentally defectives are not so intellectually



equipped their crimes are of stereotyped nature and there is no variety in the crimes they commit.

Some crimes may be due to lack of understanding of what is right and wrong but in some instances it has been found that the mental defectives did understand the moral and legal implications of the behaviour in which they were going to engage and still they did it. In such cases the individual acted on impulse to satisfy some passing whim which he could not control.

Juvenile delinquency is also connected with feeble-mindedness, but this prejudice is also due to human weakness to seize upon any striking fact as the most important factor in the phenomena. A feeble-minded child who is frequently bullied and tormented in the school by both fellow children and teachers is sure to retaliate by violating all rules of the school. He may indulge in acts of cruelty or deliberately damage school property or run away from school. Often such children indulge in petty stealing too not because they need stolen things but just to pay back for the unkind treatment they received from others. Not seldom are feeble-minded girls exploited by unscrupulous persons for sex offences. It is, therefore, for society to protect young delinquents.

Popular thought also associates psychoses with mental deficiency and many people are not able to distinguish between the two. We have already seen that many psychotic reactions involve mental deterioration and such deterioration is a part of their psychotic behaviour, the disorganization of their emotional and intelligence make-up. It is often very difficult too to assess the intelligence of psychotics correctly because even if he knows the answer to a test question correctly he may not be able to express it. And what he goes through during his mental illness may also affect his general attitude to tests. A person who is isolated from society as a psychotic patient may forget several things. Mental defectives may also develop any psychotic condition but not because of their mental deficiency entirely.

#### *Treatment of mental deficiency*

No remedy for the treatment of mental deficiency has yet been discovered and what therapeutic attempts have been made have not yielded any satisfactory result. Feeble-mindedness is



inherited and congenital, and young people do not outgrow or make up for their inborn retardation with maturity. It is not possible to change a feeble-minded child into a normal child either by medical treatment or by superior training. Some progress has been made with the help of neurosurgery but this technique can be applied only to cases of head injury or of hydrocephaly. But whatever attempts we make to treat a certain type of mental deficiency we must diagnose it very early.

Some cases of mental deficiency have been treated with glutamic acid and they have shown significant improvement. Children have grown more alert and efficient, but they are not cured in any sense of the term. When the drug is stopped they go back to the original condition.

But the prospect is by no means entirely discouraging. With suitable training and guidance the feeble-minded children can be helped to make the most of what mental equipment they have. Morons can be taught to look after themselves, to avoid danger, to acquire habits of self-management and cleanliness and to develop favourable social qualities, and if such training and guidance is started early in life and if their physical welfare is carefully looked after these mental defectives who are a liability to their family, society and country may well become an asset making their living and becoming satisfied and useful members of society. They are a psychological, educational, socio-economic and medical problem, and all agencies of the country, the state, the family, the school, and the community should work together to help them find their feet and a useful place in our social economy.

Parents of mental defectives usually feel disappointed and worried about their children, some of them may be holding themselves responsible for their defect and may harbour feelings of guilt, some may be expecting too much from such children and then rejecting them in favour of other more fortunate children. They may feel frustrated and may not give them the affection and care which all children need at the hands of their parents. In such an atmosphere children are sure to feel useless. So the first thing to do is to educate the parents to accept their mentally deficient child as he is and strive their utmost to give him the best possible care and training so that he can make the most of what ability



he has. He may be given special guidance and training to develop favourable social qualities in his personality and to develop strong interests in manual work, both of which will make for his usefulness and happiness. What cannot be helped must be endured with good cheer and within the limitations of his intelligence opportunities must be provided in the home for gaining self-confidence and a sense of worthiness. These children require much more time and patience, they will learn and respond to training very slowly but given the helping hand of parents and the assurance of their affectionate regard these children will find happiness in life. They should be treated by parents as normal children are treated. Rejection is as harmful as over-protection on the part of parents. While tasks should be suited to the ability of the mentally defective child he should not be protected from the challenge of his physical and social environment and he should not be made over-dependent on adult help.

To begin with such children should be guided to wash, dress and feed themselves, to walk and manipulate common things needed in daily living. Personal cleanliness and looking after his personal needs and things is an important thing to teach. Small tasks should be given and the child should be taught lessons in responsibility. Keeping his temper in control and developing a pleasant attitude to things and persons around is a great moral lesson which mothers should help defective as all other children to learn. They should be encouraged to play with normal children but the latter should not be allowed to make fun of them or in any way breed inferiority feelings in them.

Usually only borderline cases of mental deficiency are admitted to Indian schools and idiots and imbeciles are refused admission. Only morons can benefit by school attendance, but it must be clearly appreciated that they cannot work with normal children and should either be sent to school late, say at the age of eight or so or sent to special schools meant for feeble-minded children. Education in India is not organized to suit individual differences among children and the slow are allowed to mark time and waste precious life in common schools. But educational effectiveness demands that they should be placed either in special classes or



sent to separate schools meant and designed specially for them. In common schools they are compelled to compete with normal children and get the bitter pill of failure and frustration losing all interest in their work and study. With specially designed courses and separate schools or classes they will be saved the humiliation of failure. Usually in the western countries special courses with manual work requiring motor coordination and motor skill are set for them and they are encouraged to speak and develop social habits. Their classes should be small to enable the teacher to give them individual attention and to let them learn and develop at their own rate. They will take longer time and the teachers of feeble-minded children should be specially trained to exercise patience and understanding with them. No special provision is made for such children in the educational system of this country and we have yet to learn to utilize this human material for individual and social usefulness and happiness.

In some countries like Belgium such children are placed in homes in rural areas where they receive family care. No such provision is available in India.

There should be a well thought out programme for imparting vocational training to mental defectives so that they can support themselves or at least contribute to their upkeep and maintenance. It may be farming, laundry, kitchen work or simple manual work in any craft. They can also be taught to tend cattle or help in dairying or poultry. Since they are not capable of making adjustments to new conditions they should be put on routine work.

In the United States there are laws prohibiting the marriage of mental defectives and sterilizing them but such measures have not yet been taken in India. Prevention is the only method of reducing mental deficiency though efforts to find effective medical treatment continue to be made.

## QUESTIONS

1. What do you mean by feeble-mindedness? How will you diagnose it? Has it degrees?

2. What are the several grades of mental deficiency? Describe them and discuss how and what provision can be made for them in society.
3. Describe some of the important clinical types of mental deficiency and suggest possible treatment.
4. Discuss the relation between feeble-mindedness and delinquency. Are criminals mentally defective?
5. What are the main causes of mental deficiency? Discuss some of the measures which should be taken for the training and help of the mentally defective children.
6. Discuss feeble-mindedness from the family and state point of view indicating what should be done by the two agencies.



## Criminal and Anti-Social Behaviour

Criminal behaviour is described as anti-social, that is, it violates the accepted social norms and standards of conduct in any community which are embodied in, and enforced through, laws. Such violations are followed by punishment proportionate to the extent and severity of the crime.

What is criminal varies with time and place, though some crimes are universal as stealing, murder, treason. Even in these there are exceptions. Laws differ from country to country and age to age. Only a century or so back pick-pocketing was punished by death in England but today the offender may receive only a light punishment. During prohibition the sale of liquor is a crime and when prohibition is lifted it ceases to be so.

In all cultures there are standards and laws are made to support those standards. We have religious standards supported by rules of churches, moral standards are supported by moral rules and legal standards are supported by laws. The violations of laws are called *crimes*, the violations of religious rules are called *sins* and the violations of moral rules are called *immorality*. The laws are framed to establish a social order and promote and secure social welfare and progress. Without laws society would be unstable, disorganized and meaningless.

### *Juvenile delinquency*

When young people below the age of eighteen or sixteen indulge in criminal and anti-social behaviour it is referred to as *delinquency*. This age limit varies from one state to another but the young offenders are known as *juvenile delinquents*. A delinquent young person is disobedient and wayward, runs away from home and school, cannot be controlled by his parents and teachers, is not amenable to any kind of discipline, is self-willed and habitually acts in a manner injurious or risky to the welfare and happiness of others and himself. Most progressive states have set up courts to try juvenile offenders and send them to

corrective homes or special institutes like the Borstal Institutes or reformatories. There are special magistrates set apart for the purpose.

Juvenile delinquency is much more common in cities than in rural areas and includes all the crimes which adults may commit plus those which are specially within the reach of young people like running away from home and school. Though courts are inclined to judge young offenders rather leniently their offences may be more serious than those of adults.

### *Types of crimes*

On the basis of the severity of offences crimes are grouped under three heads : *treason*, *felony* and *misdemeanour*. Treason is a very grave crime against the security and integrity of one's own country ; the offender may be described as waging war against his own state or rendering help to his country's enemies and thus endangering the safety of his own country or nation. Felonies are serious crimes such as stealing, murder, fraud, robbery, arson, rape or assault ; they may be punished with death, long imprisonment or heavy fines. Misdemeanours are minor offences like drunkenness, disorderly behaviour in public, driving without licence or violating rules of the road ; such offences only subject the offender to a small fine. It is obvious that the number of persons found guilty of misdemeanours is much larger than those found guilty of felonies. A distinction is sometimes made between crimes against property like larceny, expropriation, burglary, and crimes against person like assault, murder and rape.

### *Sex and age of criminals*

A large majority of those who are convicted are male. This majority ranges from 85 to 95 in the case of arrested and convicted offenders. Very few females are guilty of crimes. May be that their sphere is mostly within the four walls of the home and their cultural training influenced by social tradition is different or that the police deals with them more leniently and they are less frequently brought to book.

Most of the criminals display anti-social behaviour in the first part of their lives. In the western countries the average age



of convicts ranges between twenty-five and thirty. Juvenile delinquency makes its appearance in the early teens, about fifteen to be exact.

### *Dynamics of crime*

Why do people take to crime? What factors contribute to the spread of crime? Do specific traits of personality tend to make a person prone to anti-social behaviour? What are the characteristics of an anti-social personality? What factors determine it? These topics will be discussed here, and our discussion will consider biological, social and psychological factors in crime.

*Biological factors:* As we have seen in previous discussions the first factor to which all students turn is heredity. Is the tendency to commit crime inherited? It is difficult to affirm that people are irretrievably pushed into a life of crime and anti-social behaviour because their parents and ancestors were criminals. Of course, there have been cases of families distinguished for crime and in the records of the Government of India there is mention of *criminal tribes* as a statutory section of the Indian population. Now when a certain tribe is so named and in the family and the community there is a rank atmosphere of anti-social behaviour every child will take to crime as easily and inevitably as every child born in a carpenter's home takes to carpentry. But this is the influence of home environment and not of heredity. However, in some cases it has been found that certain physiological and mental traits in the make-up of an individual make him respond to the crime situations in life more favourably. The importance of heredity in such cases cannot be ignored. Again certain defects of personality are inherited and they are associated with criminal tendencies. But in mild misdemeanours and petty crimes heredity is of no relevance. Evidence from investigations of families and twins is not conclusive. Gluecks who made an extensive study of criminals and delinquents could find only 50 per cent of them having a family history of crime and delinquency. Rosanoff who made a study of twins found that if one twin was criminal the other was also a criminal and the percentage of such cases was as high as 70. Naturally such findings would incline him to attach great



importance to heredity. Heredity is not so significant in juvenile delinquency. A very small percentage of young delinquents give evidence of family history.

Lambroso, an Italian physician, tried to gather evidence in support of the biological basis of criminal behaviour and argued that high, pointed head, low receding forehead, large protruding ears and projecting eyebrows are associated with criminality. But all such investigations are obscured by the influence of social and psychological factors, and there have been other studies completely repudiating Lambroso's theory. Nor has any relation been established between endocrine glands' functioning and crime.

*Social factors* : Numerous studies have been made to show that social factors are very significant in crime. No society is free from crime but crime thrives in some sections of society much more easily than in others. The prevalence of crime in society shows how unstable and disorganized it is. Rural communities which are very closely knit and where customs and traditions are very powerful are less criminal than towns where people are living in a mass without any social organization or order. Even in towns some parts are more criminal than others. Slum areas are notorious for being the residence of criminals, and the same cannot be said about swell civil areas. In the latter there are conventions of decent behaviour, but other areas where there are no such standards of behaviour, where social disorganization is great, and where the behaviour of a resident is of no moment to his neighbours crimes breed. These are not causes of crime but only favouring conditions for anti-social behaviour. The importance of environment, therefore, cannot be ignored. Conditions in the home are also an important factor. Loss of parents, broken homes in which the husband or the wife has left, divorce or disruption in the family make for delinquency and crime, but there are examples of children from such homes having made a mark in life and figured as very useful citizens. However, happiness in the home is significant. Delinquents usually come from homes where there is no love and affection, where they are not wanted or cared for, where there is no discipline, where parents drink and indulge in immoral behaviour, and feel no responsibility. Or they come from homes where discipline is too strict



and every step they take is watched and supervised. Many delinquents have step-parents or have been brought up in orphanages and foundling homes. Some criminals are illegitimate children. A good many delinquents left their homes early for one reason or the other. A large number of criminals arrested and convicted were either divorced or widowed, in any case their number is larger than that of married people.

*Economic factors* are no less important. A majority of criminals come from very poor families or have been unemployed. A good many of them are engaged in occupations which are not satisfying from any point of view. Many of them were unskilled labourers or doing a job which did not bring enough to fill their stomachs. But the fact that a large number of people are unemployed, poor and hard up and still abstain from crime shows that poverty and economic disability alone is not the cause of crime. And then the incidence of crime among richer people in industrial society is not negligible. One study has revealed that crime grows less during industrial and economic depression and rises when economic conditions improve.

*Racial factors* have already been discussed. No tribe or race is criminal by inheritance. It is the environmental conditions and the social climate prevailing in the tribe or race that make people criminals. Before Independence people in Northern India were agreeably surprised to see fierce Pathans taking part in the non-violent civil disobedience movement of Mahatma Gandhi. People had associated Pathans with fierceness and ruthlessness and not infrequently with crime but the new spirit of the movement made them so disciplined that the name of Khudai Khidmatgars as they were called will live in Indian history as signifying service, humanity and humility. If any race is more criminal than the rest of the population it is always because of the circumstances to which it is exposed, as is the case with Negroes in America. It is the same race of Negroes which has produced eminent humanists like Dr. E. C. Blake, Dr. Martin Luther King and Ralph Bunche, to mention only a few leaders of the non-violent struggle of that community for civil rights in America.

The influence of *war* has been studied during the two World

Wars in countries who were involved. It was found that during war the number of crimes registered a sharp decline possibly because most men were either out on the front or engaged in war work at home. This decline, however, showed only in male crime. There was an increase in juvenile delinquency perhaps because home life was disrupted, school work was disorganized and even minors were asked to work. But crime in countries not engaged in war increased both among males and females.

*Psychological factors* : People apprehended and convicted for crime have been tested for intelligence showing that most of them have a score slightly lower than that of the general population. Even among young delinquents there is a greater number of mentally deficient persons and the number of persons with superior intelligence is very small. But it may be due to the fact that people with less intelligence are more easily caught than intelligent people. Or it may be most offenders come from poor families and do not have the benefit of education. If educated criminals are compared with people of similar education there is hardly any difference in their I.Q.s showing thereby that crime and delinquency have no relation to the level of intelligence.

Criminals are found to be slightly more neurotic than other people though there are certain neuroses which are criminal as kleptomania, pyromania or Peeping Tom.

Patients of psychoses committing crimes are not punished if they are judged insane by a law court. Usually some psychiatrist is called upon to judge if an offender is insane. Another thing necessary to prove is that the criminal was insane at the time of committing the crime and that he did not understand the nature of the offence nor the legal issues involved in it. Offenders who are judged insane are not held responsible for their action and are, therefore, not given any punishment. A number of offenders fake insanity to escape punishment. Criminals suffer from psychoses as much as the general population does.

### *Psychopathic personality*

One of the most interesting clinical types of constitutional disorders, which has attracted considerable attention in recent



years on account of its legal implications, is that of *psychopathic personality* which may be defined as a constitutional disorder showing itself specially in anti-social behaviour. Though it has not been scientifically proved these individuals seem to be congenitally deficient in moral sense. These people are not insane and cannot be so certified, they are not mentally deficient ; indeed they are often intelligent and shrewd, but they are lacking in moral and social sense, and this defect appears to be due not to their upbringing but to some innate disposition, which renders the individual incapable of appreciating social demands. A psychopathic personality lacks moral and social development and the ability to follow socially approved rules of behaviour.

Several definitions of psychopathic personality have been offered but perhaps the one offered by C. O. Cheney may be cited as typical : "Psychopathic personalities are characterized largely by emotional immaturity or childishness with marked defects of judgment and without evidence of learning by experience. They are prone to impulsive reactions without consideration of others, and to emotional instability with rapid swings from elation to depression, often apparently for trivial causes. Special features in individual psychopaths are prominent criminal traits, moral deficiency, vagabondage, and sexual perversions. Intelligence as shown by standard intelligence tests may be normal or superior, but, on the other hand, not infrequently a borderline intelligence may be present." This may be the best of definitions but it is too large and involves a long list of traits of a psychopath personality. Perhaps we can do better by describing serially some of the important characteristics of such anti-social personalities. Very little is known about the constitutional basis of such personalities or the cause of this order, but inveterate pathological liars, tramps, sexual perverts, eccentrics and the like are typical examples of such a personality.

It is difficult to say how many people in society belong to this class of anti-social personalities, partly because they have to be intimately known before they can be classed in this group and secondly there is so much variety that such people cannot be grouped together. Unprincipled businessmen, revengeful teachers, quack doctors, extremely puritanic priests, crooked politicians, swindlers,



sexual perverts and prostitutes are at large in society and are never treated by psychiatrists or even told to get themselves treated. They are a nuisance to others. They are not only rebels but they are anti-social, and rebel for the sake of rebellion.

### *Symptoms of psychopathic personality*

\* Instead of giving a complex definition of psychopathic personality it would be better to describe some of the important symptoms of such personalities. Let us detail them here.

1. They are average or above in intelligence. They readily give this impression as they are very genial in their manners and very resourceful in conversation. They are quite sociable and become popular soon enough. First impressions about them are always favourable.

2. There is marked discrepancy between their level of intelligence and conscience development. Conscience is very poorly developed. The ability to understand, appreciate, accept and pursue ethical and social values is utterly lacking. They may stress and accept such values in words and speech but they are unable to translate them into actual behaviour and practice.

3. They are extremely self-centred and selfish. Their behaviour is impulsive, irresponsible, uninhibited and unrestrained. They have little regard for social conventions and are unable to consider the social implications of their actions. Their own interest and pleasure is all that matters to them.

4. They seek immediate pleasure and thrills and are unable to forego them for the sake of future pleasure or advantage, and they seldom work for the achievement of long range goals or of social beneficial purposes. That is why their indulgence in sex pleasures and their so-called free pattern of behaviour is pronounced. They live in the present, from day to day, and have no consideration for the past or future. They may change jobs very frequently and have no loyalty to any organization. All that matters to them is the gratification of their own impulses to get rid of their boredom.

5. They are not able to profit by their mistakes and common experiences so as to make their life more in tune with the norms of



social living. They know only to manipulate and exploit other people for their own ends and escape punishment if any. They have social ambitions no doubt and it is only for the sake of that that they put on charming and genial manners. They may cultivate a sense of humour and an enthusiastic and hopeful approach to life just to win and exploit people. They will tell lies, make an excessive use of alcohol and resort to all sorts of unscrupulous behaviour to create a favourable impression about themselves. It is only on close scrutiny and long experience that others are able to find out about them. Even if they express regret it is only to gain further ends. They may make all sorts of promises when they are found out but they have absolutely no intention of fulfilling those promises. They are devoid of any sense of honour or fair play, and they never feel any genuine remorse for their misdeeds. They will repay kindness with meanness.

6. Emotionally they are described as cold, callous, shallow, cruel, immature, jumpy, irritable and fluctuating in their moods. They have no control over their emotions and it is very difficult to say how they will react in any situation. Small things may upset or elate them, depression and outbursts of anger alternate without any rhyme or reason.

7. Such a person cannot be expected to have any regard for any social institution like marriage. Their marriages are short-lived affairs that generally end in failure. Their selfish, stubborn ways cannot make a success of what is a cooperative affair.

8. They are not adequate individuals and if at one time they are aggressive and assertive, at another they will be weak and passive. There is no balance in their behaviour because they have no well-thought-out plan or goal of life. Naturally, therefore, their life has no sense of direction or purpose.

9. With no social feeling, no sympathy and gratitude, their dealings with others are based on impulse and self-interest. With the result that they are unable to make any friends.

10. They have a large capacity to rationalize their misdeeds and make excuses or to project their mistakes and faults on others. They have no insight into their behaviour. Often they are a source of embarrassment to their friends and family and cause them much unhappiness.

These symptoms may often be found in several forms of neuroses and psychoses but in a psychopathic personality they are much more pronounced and do not occur with abnormal patterns of behaviour characteristic of psychoneuroses and psychoses.

Figures collected from the army in the United States indicate that about one per cent of the general population are psychopaths. Women seem to suffer less from this pathology. Their crimes do not differ from those of the normal criminal. They are capable of understanding the difference between what is right and what is wrong, and, therefore, they cannot escape law and punishment when they are apprehended. Nor are they curable. Punishment or psychological treatment has no effect on them.

#### *Theories of anti-social behaviour*

Psychoanalytical explanation of psychopathic personality lays stress on unconscious motives and repressed mental conflicts. We have already referred to the repressed wishes of early childhood such as sex, hatred of father and it is contended that these wishes find expression in criminal and anti-social behaviour. The child whose sex urge could not be gratified and was repressed may indulge in some other forbidden act which offers him the same excitement like burning property or stealing. A young person who is bullied and ordered about by his over-strict father may grow into an adult who defies all authority and takes pleasure in disobeying people in power and their rules. Crime is an outlet for the expression of repressed wishes of early childhood. Psychoanalysts are of the view that even normal persons have destructive and anti-social urges but they are either able to repress them or sublimate them into constructive and helpful activities. People support severe punishment to criminals because in an indirect way it protects them from criminal impulses of their own.

Another view is that crime is a maladjustment. When an individual is unable to satisfy his urgent wishes in a manner acceptable to society he has only two alternatives, either to give up his wishes or to gratify them in unsocial ways. He is like the neurotic who seeks substitute satisfactions. Anti-social and criminal behaviour is a form of maladjusted behaviour. Modern psychology stresses important needs like that of security, new experiences,



esteem and recognition, and self-actualization, and argues that all human behaviour is motivated by these basic needs. Under certain circumstances when normal expression and satisfaction of these needs is prevented individuals resort to anti-social and criminal behaviour to satisfy them.

Again some writers consider that the majority of criminals are neurotic characters. Crime does not pay but still people indulge in it. They are criminals out of an unconscious sense of guilt or from unconscious anti-social impulses. This is particularly true of crimes against persons and even of some crimes against property.

Alexander and Healy who examined a large number of criminals whose criminal careers apparently were due primarily to international conflicts rather than to external circumstances found the following characteristics as revealed in the psychoanalysis of a thief :

A strong sense of inferiority, leading to over-compensation in a feeling of bravado and toughness.

Feelings of guilt toward a brother and the attempt to relieve them.

Spite-reaction toward his mother.

Desire to indulge in a carefree, vegetative existence.

Gratifying his infantile, parasitic wishes, satisfied by existence in prison.

But these authors admit that the "bottom of the difficulty" has never been reached by way of personal, social and psychiatric investigation and treatment.

### *Treatment of criminals*

As readers must have seen that there is a great deal of confusion about the dynamics of criminal behaviour and anti-social personalities. We are not sure about the source and origin of this type of behaviour or personality. The criminal is a psychotic who should be treated in a hospital. In fact methods of treating criminals have not improved even with rapid advances in both psychological studies and sociological thinking. If anti-social behaviour is due to some organic defect it is not yet identified and attempts to treat it with drugs are not considered. Treatment is

rendered still more difficult because these individuals usually have no desire to change. Therefore, prospect for the recovery of anti-social personalities is not favourable.

It is reported that some cases have shown improvement under hypnoanalysis and in some selected cases brain surgery had to be resorted, but as a rule most criminals show considerable improvement after the age of 40. It may be that their instinctive urges weaken or that they gain some understanding into the nature of their behaviour through experience or perhaps social pressure to make some outstanding achievement in life grew weaker. Any programme of treating anti-social personalities must aim at fostering in them a sense of responsibility, emotional maturity and stability and an appreciation of moral and social values but such attitudes can be developed only under the stable and regulated influence of an institution, and as anti-social and criminally inclined individuals are seldom sent to any hospital or reformatory institution other than punitive ones they seldom recover from their criminality. Society has never given any thought to giving them long range treatment in organized institutions. Perhaps a more practical step would be to try to detect and treat anti-social tendencies in children and thus prevent their development in the direction of crime.

*Punishment* : For very long in human history the only treatment society gave to the criminal was punishment and much time and effort every generation has spent in devising punishments suited to the severity of the offence. Since the social importance of different types of crime have changed from one age to another these punishments have been changing. As has already been pointed out that a century back pick-pocketing was considered a very grave offence and the offender when caught was always punished with hanging. Today it is not considered so grave an offence as to deserve capital punishment and the offender gets away with a light sentence. The quality and intensity of punishments have, therefore, varied with the moral consciousness of the society. In several Indian States before Independence severe punishment like cutting off ears and the like was given for thefts and burglaries, and in several semi-civilized countries even today public flogging and execution by beheading is practised. In civilized countries punishment includes hard labour, difficult living conditions, solitary



confinement, very harsh discipline and execution by hanging or the electric chair.

Punishment is supposed to achieve three things. In the first place it is a sort of revenge or retribution. The criminal has done wrong and gets the punishment as a reward for his conduct. He has injured society and its laws and, therefore, must suffer. By awarding him punishment society vindicates the sanctity of the law. The offender is purged of the crime by suffering punishment. A tooth for a tooth and a nail for a nail, and punishments must be proportionate to the seriousness of the crime. The second object in inflicting punishment on the offender was to deter others from committing crimes. That is why in olden times physical punishment even executions were administered in public so that people might see what fate awaits them if they misbehave. Thirdly, it was supposed that the offender would be so impressed by the severity of punishment that he would not again dare to do it and thus punishment would help to reform the individual offender. Anybody can see that human society has been organizing punitive measures from the most cruel and barbarous to the most humane and organizing elaborate institutions for offenders all along its long history and yet we are nowhere near either in reforming the individual offender or in deterring others from indulging in anti-social behaviour.

Punishment has failed to achieve its objects, but it continues to be practised in all countries. It is fairly clearly recognized today that penal institutions instead of reforming the convict help to make him a hardened criminal and an avowed enemy of the social order. Often the punishment is out of all proportion to the gravity of the crime, there may be miscarriage of justice or the people entrusted with the administration of justice and punishment may be too cruel, vindictive and callous so as to rouse the convict to further vengeance against society of which they are the agents. So all those who have to deal with the administration of justice and punishments are today convinced that punishments do not achieve the object for which they were meant, but the whole procedure and practice continues, perhaps for want of another better. So they are now thinking in the direction of modifying the penal codes and the treatment of prisoners, and a more

positive and constructive approach is emerging. In all enlightened communities it is being increasingly realized that during his jail term, the criminal should be re-educated, re-socialized and rehabilitated in society to which he will return after serving his sentence. Large scale reforms of prison life are under way. There are open-air jails, inmates are encouraged to learn some craft or do farming and if they earn, a part of their earning is credited to their names so that when they leave they may have something to fall back upon. The authorities show a growing awareness of the objectives of punishment, try to understand each individual offender and to take such steps as will help him to become a self-supporting and law-abiding citizen. Supervision too is relaxed and convicts are allowed considerable freedom to move about. In one Indian state they are allowed to work out in the fields and trusted with responsibility to inspire greater self-respect in them. Let us detail out some of the new things introduced.

1. Many first offenders are granted probation particularly if they are young. A good many become offenders by accident and if they were grouped along with hardened convicts they are sure to become worse and take to life of crime without any compunction. The company of jail birds is never a very happy thing. So they are kept out of jail and their life is supervised by well-trained probation officers.

2. Criminals have large individual differences and have to be given individual treatment. Some are very sensitive, others are very callous. It is obvious that harsh treatment given to prisoners be adapted to the corrective needs of each prisoner. Again some prisoners need greater supervision than others, some have still some sense of shame others are quite shameless. Since our task is to re-educate individual prisoners we must modify our treatment to suit individual needs and sensibilities of prisoners. Prisoners who are hardened criminals must be given more strict supervision than those who are first offenders. Again prisoners who are mentally defective, psychotic or mentally disturbed may have to be kept in separate institutions. And those who respond to jail treatment should be given remittance in the period of jail custody.

3. We have very vivid accounts of barbarous treatment meted out to prisoners who were lodged in underground cells all alone and



given bad food, and all sorts of tortures. Modern prisons are much more humane. Corporal punishment, solitary confinement, rules of silence, killing overwork, and other extreme forms of punishment have been mostly given up. The grind of heavy unbearable manual work has been considerably modified, and the over-strict discipline has been released to meet the requirements of each individual prisoner. Living conditions and food has been very much improved, and supervision means guiding rather than guarding.

4. Old prison houses were very dull and boring places not to mention their harsh cruelty and degrading programmes of work. Today prisoners have relaxation and recreation programmes, they are encouraged to take part in cultural programmes, social gatherings, discussions in groups and supervision duties. A degree of self-direction is allowed so that the feeling of being in jail may be reduced a little and the inmate feels that there is an opportunity to make good and turn a new leaf in life. Many convicts learn a useful vocation and it is a commonplace in India that jail carpets are preferred. Many convicts become very good craftsmen and are able to make a satisfactory living after completing their sentence. The illiterate are taught reading and writing and given rudimentary education. There are library facilities for the educated and classes and lectures are held for those who wish to acquire more knowledge of the world. Audio-visual aids like films are also used to make such learning and education more cheerful and effective. Many jails have regular religious services and offer prisoners opportunities to serve each other.

5. Prisoners are allowed to earn remissions of their sentence by good behaviour and some are able to reduce their sentence considerably by behaving better in strict conformity to jail rules and doing useful service to the authorities.

But by far the most important thing to do is to offset the stigmatic effects of jail sentence. Most countries are not able to do anything about it, and once a person has been convicted he is made to suffer many political and social disabilities. The disgrace of having been convicted is not easy to remove unless one is convicted on political grounds. And then in India of today political imprisonment in pre-Independence days is being rewarded with jobs and state benefits.

*Prognosis*

Some follow-up studies have been made of prisoners and they show that about 50 per cent of the prisoners have had one or more previous convictions, and a large percentage of released prisoners committed offences within five years of their release. On the other hand thirty per cent of them did not again indulge in any crime. Glueck thinks that decrease in the criminality of released prisoners is not due to prison treatment but to growing maturity and aging of released convicts. There is no difference between men and women prisoners. Female prisoners resuming their criminal life are almost of the same percentage as men prisoners.

Probation treatment is more effective and a large number of people kept on probation never take to crime again. For first offenders the percentage is much higher.

Seventy-five per cent of the people who are kept on parole complete their parole without committing any offence. This supports the method of keeping people on parole but parole by itself is not enough to rehabilitate offenders in society.

*Treatment of juvenile delinquency*

The treatment of juvenile delinquency has to be different from the treatment of adult criminals and here society has followed more rational and progressive methods. In India too courts for the trial of young offenders have been set up only in large towns. The procedure in juvenile courts is different from the routine courts trying ordinary criminals. These attempt at fuller understanding of the young offender with a view to help him rather than to punish him. The cross-examination is replaced by detailed interviews in which the offender is persuaded to confess his offences, and the more serious offences are tried in regular courts. But judges of these courts have wide powers and they are not bound by legal procedures and statutes. Usually the offender is dismissed with a warning or sent to a corrective home or a reformatory. Nearly half the cases are dismissed with a warning and parents and teachers advised to keep a watch on him or her.

But it all depends on how well the probation officers are trained and what qualifications and training the judges or



magistrates of juvenile courts have, what progressive methods are used and what is the general approach to juvenile delinquents. While in a reformatory of the progressive type delinquents receive wholesome food and suitable physical exercise, their health needs are attended to and they are given facilities for educational and vocational training. There is a varied programme of social and recreational activities and young people are encouraged to assume social responsibility as a step toward their social rehabilitation. But it is doubtful if their emotional needs are also provided for. The probation officers and the parole supervisors are unable to gratify their needs for affection, friendship and kindness. That is why facts and figures collected from countries where treatment of juvenile delinquency is very systematically organized do not show any favourable results after treatment.

The treatment of delinquency is an all-round complex problem. It is obviously a problem for education, sociology, economics and individual psychology. Here we can discuss it only from the standpoint of psychology, as a psychological problem of the individual. The problem is easier of solution if it is taken up early in childhood or adolescence. Much will depend on the intensity of his involvement in the gang. The therapist has to be with him for a good deal of time and get him emotionally attached to himself by encouraging him in his thinking and making him talk freely. He may even appeal to his vanity that the young delinquent is very clever and knows much more about crime than he does. Later, however, the therapist surprises the young delinquent by telling him that there are many more methods that he knows. It is at this stage the young person is made to realize that knowing some very clever methods the therapist pursues social goals and using his attachment persuades the delinquent that social goals are better than the life of crime. If the group ties with the gang are very strong such a treatment will not make much progress.

There are young delinquents who are neurotic and the best thing to do is to give them psychological treatment for their psychological troubles. Those with abnormal personalities or personality defects are more difficult to treat.

*Prevention of crime.*

Prevention of crime and delinquency is a complex problem and several areas of life and work are affected. The problem is not one for psychology alone to tackle and solve, but courts and legal practitioners do somehow look up to psychologists to offer a solution. This can be done only within the limits of psychological study and psychiatry. A few suggestions are made here.

1. The objective of education to develop all-round balanced personalities in young people should be understood and appreciated by all agencies influencing children, the school, the home and society, and these agencies should work in close cooperation. If young people are not only given knowledge but also taught useful skills and given refined feelings their criminal and anti-social impulses will be directed into constructive channels. But the germinal seeds of such impulses are to be found in very early years of childhood. If the emotional climate in the home is favourable and if parents, brothers and sisters maintain very friendly relations with the child, their social and moral education will be guided by them and they will learn to function in the family group with due regard to the feelings and interests of others. Character development is the result of social experiences, and if these are happy and normal children will turn to good things of life. The church, the school, the neighbourhood, the play group and the scout organization, all can make a very substantial contribution to the emotional and social development of the child and lay the foundation of sound social and moral values in the character and conduct of the young person. Some schools have regular programmes of hiking, visits to historical and geographical places, social service and the like, and these can be fruitfully utilized to bring home to young people to share group responsibility and group loyalty which is the backbone of good citizenship.

2. Abnormal psychology has done a remarkable service to the cause of education in stressing the importance of experience of early childhood and how they make or mar the personality of every adult. Parents and teachers, therefore, should always be very vigilant for any anti-social urge on the part of children under their care. People do not take to crime all of a sudden,



there is always a history behind, and this history consists of experiences, urges and temptations, and emotional conflicts. It is for teachers and parents to smoothen the path of life for children not by making things easy for them but for building in them a wholesome strength to meet the challenge and difficulties of life in a positive and constructive manner acceptable to the group to which they belong.

3. We have suggested some of the possible causes of crime and if the state wishes to eliminate crime it cannot do better than remove those conditions which lead to criminal behaviour. It is provided in our constitution that every child should be given the necessities of healthy and sane living so that he or she can make the best possible use of what talents nature or God has given him or her to the best advantage of the society and country to which he or she belongs. It, therefore, behoves the state to abolish slums, improve housing, health and education facilities, medical aid and nourishment, and to provide for the social and cultural development of all future citizens. This is a stupendous task no doubt but the perspective has to be clearly appreciated.

4. Group life in both the home and the school should receive more careful attention of teachers and parents. And even those who have nothing to do with schools should lend their help in checking such impulses of children as are anti-social. Some years back an attempt was made to enlist the support of the general public in checking juvenile smoking. Similar attempts could be made with regard to children's gangs.

5. Good administration and a vigilant police force are very necessary for reducing and eliminating delinquency. If people understand that they will be caught they will desist from crime but if they are confident that chances of their arrest are very thin they will misbehave readily and with impunity.

6. In many democratic countries politicians are in league with the cells of criminals and enlist the support of bad characters for political ends. Unless political leaders set an example of behaviour which is above board and socially ideal there is little hope of reduction in delinquencies or crimes.

## QUESTIONS

1. Describe some of the common delinquencies of Indian boys. What are the causes of juvenile delinquency? How will you deal with it?
2. Discuss the biological, social and psychological factors in crime.
3. What are the symptoms of a psychopathic personality? How will you deal with it?
4. Discuss some of the theories of anti-social behaviour.
5. Discuss fully how crime should be treated in any society.
6. Why do we punish criminals? What is the object of punishment? Is punishment an effective remedy of crime?
7. Suggest some effective measures for the elimination of crime.
8. Discuss some important measures for the prevention of crime in society.



## Mental Hygiene

In 1908 was published a famous book, *A Mind that Found Itself*, by Clifford Beers, a Yale graduate who became a mental patient shortly after passing out of the university. He received very bad treatment in three typical institutions of the day. Though he was not tortured and chained as was done to patients in olden days the treatment was not at all humane. He tells the story of his illness, of what treatment he received and of his recovery at the house of a friend. He felt that the treatment was painful and cruel and did great harm to a patient who was already overwrought and needed very badly the quiet and peace of an understanding and affectionate home. On recovery he resolved that this was not the proper way to handle the mentally sick and that something should be done to make people realize that such treatment was wrong and ineffective. His book made a strong impact on the American public and he was successful in arousing strong interest in the health and treatment of mental patients. He had the support of two eminent psychologists, William James and Adolph Meyer. And through his initiative was born the mental hygiene movement to educate the people to an understanding of mental illness so that mental patients instead of exciting horror and fear are given kind and sympathetic treatment. The first Society for Mental Hygiene was formed in 1908 and it later developed into the National Committee for Mental Hygiene which in 1919 grew into a world-wide movement in the form of International Committee for Mental Hygiene with branches in all progressive countries. It publishes a journal, *Mental Hygiene*.

This movement has played a very significant role in the development of modern psychiatry. Arousing public conscience in the matter of treating mental patients it has helped in setting up children's clinics and in other measures designed to detect and diagnose early the seeds of mental disorders so that more serious developments may be prevented.

*Mental Hygiene*

In this book various types of mental disorders have been discussed. It is the aim of psychiatry to try to cure these disorders. It is the function of mental hygiene to prevent them, to maintain mental health and prevent mental disorder. In doing so it also discovers the causes of mental disorders so that their prevention is done more effectively. In actual practice mental hygiene also includes the early treatment of mental disorders so that further aggravation of the disorder is prevented.

Throughout this book we have stressed that early treatment of mental disorders is an urgent problem, partly because they are much more widely prevalent than is supposed, in fact, there are very few people who do not have one psychoneurotic trouble or the other, and partly because they are a source of great distress, suffering and incapacity. Once developed these mental disorders are very difficult to cure, and there are not enough trained psychiatrists, treatment needs lot of time and money and everybody cannot afford it. Therefore, it is much more convenient and easy to prevent them rather than try to cure them later. Once complexes are formed they are most difficult to uproot. Therefore, we should have an intelligent programme of building up mental health from early childhood, and different agencies like the school, the home, the church and social institutions should have great awareness of our present day mental health problems, take interest in all that helps and obstructs mental health and make a sustained effort to promote and improve mental health. It is, however, very strongly stressed that there should be a co-ordinated effort to prevent mental illness and promote mental health. There can be no greater value to the human race, its present and future, than the normal, efficient, happy and well-adjusted persons whose mind is free from perversions and distortions. The effects of mental disorders or unstable, disturbed and perverted minds are not confined to individuals alone. We all know to our cost how one fanatical person in a mob is able to rouse them to violent aggressive and destructive behaviour, how one disgruntled worker is a spark for the mass of workers to burn and destroy property, how one madly excited student is able to spread wild hysteria among his fellows and rouse them to break rules, glass-



panes and flower pots. Recently public agitations in the country have grown in number and intensity, a vast majority of those who take part in them are reasonable and steady persons but they are easily persuaded by a handful of fanatical, agitated and unstable individuals to throw reason to the wind and indulge in activities which in quieter and more sober moments they greatly regret. One individual, unstable and disturbed; destroys the morale of his immediate group who in turn affect others and thus the chain reaction is started and a spark grows into a conflagration. All over the world there are groups and sections which cherish one set of ideas and values, one pattern of life and social organization and they are unable to see how others can think differently or live happily and effectively in a different social order. What is worse they try their utmost and use even violent means to convert them to their own way of thinking and to their own way of living. Such maladjustments spell disaster for the group, the community and the country in which they live, and may ultimately spell disaster for the whole human race. Wars have been made by insane and perverted people is not altogether incorrect.

Mental hygiene is a positive science in so far as it seeks to establish conditions which promote mental health and prevent mental illness, to make people more health conscious and to give advice and guidance for a programme of health building. It is a normative science as well in so far as the ideal of mental health is implicit in its programmes, procedures and techniques. It places before the people a standard of mental health which they all must try to reach. It is an applied science in so far as it seeks to apply the principles of mental health for making people mentally healthy and giving them happiness and efficiency. Healthy, happy and efficient individuals will improve the community in which they live.

### *Mental Health*

Mental health is a problem which concerns everyone. While we live we all strive to live better, to realize a life fuller, happier, more harmonious and more effective. Health is a state of complete physical, mental and social well-being of an individual, and mental health is a condition which permits the maxi-

mum development, physical, intellectual, and emotional, of the individual, in so far as this does not interfere with a similar development of other individuals.

All of us are born with certain possibilities for growth and development, and mental health implies that we have found opportunities for their expression and development and realized all that is best in us. Human beings have a tendency to look beyond the horizon and cherish what they are not. We all have dreams of what we would like to be and are not. We all have ideals which we seek to realize. Our values and ideals show the direction in which we strongly desire to grow and develop. Our mental health is a realization of our ideals and values in varying degrees.

Mental health is most easily understood when we compare it with physical health. We all recognize that we are physically healthy when all parts and organs of the body are functioning well and in complete harmony with one another and we are free from aches, pains or other signs of physical disturbance. Similarly we are mentally healthy when our personality is functioning well, when all our powers and abilities, needs and urges with which we are born, and all the functions and urges which we acquire in the course of our experience find expression and fulfilment in harmony with one another, and when we are free from persistent emotional disturbances. We are born with certain needs, for example, the need for food, shelter and sex, for fighting an enemy, fearing a danger and protecting our children. As we grow up we acquire more needs like those of security, affection, superiority, mastery and self-expression. Personality becomes richer and fuller, and living is healthier and happier if all these needs and functions are expressed and fulfilled in a very harmonious and co-ordinated manner. This harmony and co-ordination of needs and functions is made easier to achieve if they are directed toward a common aim or end of the personality as a whole. Thus ideals, aims and purposes are very essential for mental health.

Obviously some goals and purposes are more capable of directing and developing our powers and talents, of fulfilling our needs and wishes. Renunciation of life and its accessories is one goal which does not use all our capacities and wishes, and is, therefore, not conducive to mental health. Rather such goals one-sided



and uncommon may produce neurotic troubles. When we seek the nature of right goals we must keep in view not only the individual good and happiness but also the social good and social welfare.

Such a view of mental health is dynamic. It does not emphasize any mental state of health but mental functioning toward the realization of goals in harmony with individual good and happiness and social welfare. Such a definition of mental health may lead to differences in actual practice consistent with the needs and interests of the individual and the demands of the community in which he lives. The principles of mental health are the same for all but differ in their working with each person.

Let us have a picture of the person in mental health. Such a person responds to the needs and problems of life without strain, his dreams and ambitions are such as can be realized in practical life. He has a shrewd understanding of what he can achieve and what is beyond his abilities, he accepts his limitations while he does not give up striving to do better. He renders help to others as readily as he accepts help from others. When he fails he does not give up in despair but tries to readjust himself for a better and stronger effort, and when he succeeds he does not lose his head. He is inclined to make friends as also to give fight to those who injure him. He can be relied upon, there is some consistency in his life and behaviour and he is true to himself. He does not make excessive demands on his friends, and his opinions, beliefs and ideals are a source of strength to him.

### *Mental health and adjustment*

We usually speak of a mentally healthy person as well-adjusted to his environment, his friends and to himself. Opposed to adjustment is maladjustment. When a person is well-adjusted it does not mean that he has no worries or anxiety. Good adjustment means that he is able to solve his problems and difficulties, he knows what he wants, whether he can get it or not and how he should set about getting it, that he faces his problems realistically, and that he is able to handle his emotional conflicts satisfactorily. Adjustment does not mean that the person moulds himself according to the nature of the situations in which he is placed but that he changes his environment as well as himself

to bring about harmony between the two factors of life. His world and life may arouse in him diverse emotions like fear, anger, grief, joy, hope, and disappointment, he may be assailed by worry and anxiety, he may have had frustrations and may be forced to feel stupid, but he gets over such feelings and does not let them overpower him. People around him may have different thoughts and beliefs but he puts up with such differences.

He also adjusts himself to his inner life of thoughts and feelings, desires and motives, goals and purposes. He practices self-acceptance. Self-acceptance does not mean that he should take himself for granted but the recognition of faults and limitations so that he lives in peace with himself. That is why it is stressed that self-acceptance should be based on self-understanding. Many people in their study of human behaviour get so morbidly interested in their own thoughts and feelings that they develop a feeling of inferiority, but a close study of numerous people around him will reveal that untold numbers of people are living and working effectively in life and have the same or similar common faults and weaknesses.

Abnormal maladjusted people are at war with their environment, they do not get along well with their companions, and they are always fearing threats or hostility from them. Their ambitions and aspirations are too high and consequently they are too easily frustrated, worry and anxiety become their life companions, and they can escape from this prison house which they have made for themselves only by denying reality and taking shelter in self-deception or alcohol.

### *Preventive measures*

After studying how personality develops and to what stresses and strains it is subjected we have to consider what preventive measures should be taken to ensure mental health. There are always external and internal problems and the individual is called upon to tackle them to the best of his resources. He has to gratify his biological needs and also to satisfy his needs for security, self-esteem and self-actualization. For the satisfaction of these needs he must be placed in a favourable environment with regard to his social group, occupation, physical health, beliefs and ideals.



Satisfactory adjustments in these as in life and work will ensure sound mental health. What must be done to ensure such satisfactory adjustments?

Biologically two important measures emerge. In the first place efforts should be made to ensure for every child good heredity. Every child has a right to be well-born which means not only excellent parental care, normal safe birth and good fetal development through nourishing food and helpful care but also preventing sub-normal parents to breed through sterilization, birth-control, marriage-control and other eugenic measures. Controlled breeding alone can ensure for the coming generation sound heredity. In our country even good obstetric practice is not available to a vast majority of future mothers and all over the countryside very crude and primitive methods are being followed by untrained nurses. In such a situation controlled birth and the like are a far cry.

Secondly maximum physical health and vigour should be ensured for each child. This will increase his resistance to disease and later to strains of life. Health and vigour spells hope and zest and liquidates anxiety and worry, frustrations and failures. Any programme of general health measures for young people will ensure the detection and treatment of any organic defects and diseases. If this is done early a good many children will be saved and protected from mental disorders. But even this is far beyond the reach of a large number of children in our country. Medical facilities are poor in quality where they are available and altogether absent in rural areas. When routine check-up is not possible detailed medical examination for every child is out of the question.

Psychologically the preventive measures should be mainly concerned with building up a sound, adequate and well-adjusted personality. If young people develop a balanced and well-integrated personality they will stand the strain of fears and anxieties, frustrations and failures with equanimity and courage. It has already been stressed that early years are very crucial for personality development and shocks and conflicts received in early years influence the attitude of an individual throughout his life. Therefore, childhood is a very crucial stage in the development of

an individual and every care should be taken to equip children with attitudes and habits which will help to withstand pressures and challenges from their environment. They are sure to meet many difficulties in the satisfaction of their physiological and psychological needs but if they have health and efficiency, if they have been taught to take difficulties in their stride and if they consider failure and defeat as an occasion for renewed effort they will be able to make happier, healthier and more efficient adjustments. If in spite of training they develop pathological trends provision should be made for the detection and treatment of such trends and adjustment difficulties. In the western countries services of clinical psychologists and psychiatrists are readily available for children in and outside the school but in our country psychological service even for general population is not yet appreciated.

Sociologically the problems of maladjustments centre round marriage and occupation. Unhappy marriages are common enough and in a country like ours where marriages for a vast majority of young persons are arranged by parents or where marriages are commercial bargains adjustments between husbands and wives are seldom happy and the two generally accept each other as an inevitable factor in their lives. There is no training for marriage, no opportunity for young people to know each other before getting married and marital happiness is sacrificed at the altar of dowry and conceit.

In occupations only a small minority selects jobs and acquires specialized training for them. For a majority of people it is the job that selects them and they get in whatever job is handy. The proportion of misfits who are unhappy and ineffective in their occupation must be very large. Large scale measures for counselling and vocational guidance and selection are not taken. For good mental health such sociological measures regarding marriage and occupation have to be taken to prevent these two factors from affecting the mental health of people.

Since preventive measures are best taken in childhood we shall discuss the role of the home and the school in mental hygiene and the measures which should be taken by parents and teachers to build sound mental health.



*Mental hygiene in the home*

The home is the cradle of the child and his future destiny has been described in song and story as the handiwork of his mother. The early formative years of childhood are spent in the home in the company of brothers and sisters and under the affectionate care of parents. Their affection and kindness give him feelings of security as nothing else does. The baby clings to his mother when in pain and is soothed by her caresses. Children who are deprived of this care and affection in early life by the death of one or both parents have been reported to be feeling insecure all their lives. Parental attitude to the child also makes a difference to the personality of the child. Let us study the effects of these two aspects of family relations on the child.

Parents' attitude to children may be of any of the four types : rejection, domination, anxiety and over-concern, and excessive display of love. Often these attitudes are mixed with one of them predominating over others. Rejection may be very subtle as when parents dislike all that the child says or does and criticize him. Domination may be all-pervasive as parents do not let the child do anything by himself and he has to seek the permission of parents whenever he does anything different from the routine. Anxiety and concern are usually shown in feelings of alarm as to what might have happened to the child in any situation. And excessive affection is displayed by fondling small infants and meeting every passing fancy they have, offering love as a reward for obedience and threatening to deny love as a punishment.

Parents may *reject* their children in two main ways, they may neglect a child by not speaking, listening and attending to him and they may show complete lack of any show of affection for them. The mother may not pick up the infant and let him cry, she may not feed him in time and she may not care to wash and clean him. Such treatment is bound to give him the feeling that the world is hostile. When he grows up he may be made to feel that he is not wanted and is not worth much. Such children grow aggressive, lack affection and withdraw from society. They are ready to fight for trifles, feel jealous, wish to gain extra attention and affection from others. Or they may lack emotional warmth. Such trends in personality are very difficult to correct.

Parents may be too *dominant* and impose a very strict discipline in the home regulating the life of young people very strictly. Some of them may be over-ambitious for their children and wish them to achieve what they missed. Then they expect strict obedience and punish children for even very small departure from what parents expect. This compulsiveness may be done with moderate methods or harshly and cruelly. Such home treatment breeds passive, timid and self-conscious personalities who are always too anxious to please everybody and may kill confidence, courage and initiative. A good many children brought up in this atmosphere may avoid parents to escape their domination.

Some parents are continually *expressing their love* and devotion to their children by embracing and kissing them, by using endearing words or by giving presents frequently. Such children may grow self-centred, they attach too much importance to their own happiness and comfort, and begin to expect everybody to pander to their needs. Too much kissing and embracing may produce sensual stimulation. Or the child may resent this over-protection and excessive display of affection. Many parents who display excessive affection generally expect gratitude from children and make undue demands on them. They may also be expressing disappointment and disapproval too often. These attitudes may be mixed and some new pattern of behaviour may result, but the elementary traits are the same.

Some parents are continually *expressing concern and anxiety* for the welfare and happiness of their children. They express alarm over a slight coughing and crying on the part of infants, over their elimination and possibilities of their illness. Many mothers are very nervous about their children and try to protect them from all sorts of imaginary dangers. This over-protection may prolong infantile behaviour in children and make them self-centred and conceited. They have an exaggerated sense of self-esteem. Such children mature late and some of them continue to depend on their parents long after they reach maturity. They may become too submissive and dependent on others.

Sane and sound upbringing in the home will treat every child in an objective manner, giving him all help and sympathy, love and affection, but respecting him as an individual who may have his



own ways of doing things and allowing him to do things in his own manner so that he may develop his judgment and self-confidence, take initiative in doing his things by himself. No child, as no human being is perfect, and parents should not magnify the faults and weaknesses of children nor make fun of them. They should be encouraged and helped to overcome or reduce them. The child is helpless and immature and needs the guiding and helping hand of his parents but it should not be forgotten that ultimately he has to stand on his own two feet and the guidance and training he receives at home should always keep this objective in view. Children will have difficulties and problems and parents should give encouragement and help in solving them. They should neither try to solve them for the child nor rebuke him for not solving them as well as they themselves can.

Again parents, at least for the sake of their children, should maintain very cordial relations between themselves. Quarrelling, separation of parents or divorce makes the child feel threatened and insecure. Parents are a very important part of children's environment and when he loses either of them he blames the other and resents his or her presence and behaviour. If one parent is absent or dies the child gets too much attached to the other. If the father dies, and there is nobody to support the family, the child by comparing his lot with other children may develop feelings of inferiority and inadequacy.

Often the place of the child in the family makes a difference to his personality. The eldest child, the only child, the only son in a family of daughters and the only daughter in a family of sons, get too much attention and are generally pampered. Such a child is domineering, selfish and weak in character. He wishes to be the centre of attention all the time and is deeply hurt even by very slight neglect or by imaginary neglects. Such children will derive great benefit from the kindergarten, from free association with children of their age. Free group play is of great benefit to them.

If there are a number of brothers and sisters, favouritism, jealousies and rivalries may be strong, and young people may develop strong hatreds and loves with consequent feelings of



guilt and revenge. Such children may lose self-confidence, may suffer in self-esteem and develop a feeling of rejection.

Therefore, for good mental health it is very essential that the family relationships should be built on sound knowledge of child psychology, parental attention and interest should be evenly distributed among children, and the individuality of every child should be respected so that nobody is harshly treated and nobody is unduly favoured. Healthy mutual relations based on co-operation and good-will and consideration for others will prevent sharp corners in personality make-up.

### *Mental hygiene in the school*

In progressive schools psychologists are appointed to give guidance to students with regard to their personal, educational and social problems. Personal problems are related to difficulties of working with classmates and teachers, of pocket-money and domestic worries. Educational problems arise out of difficulties with studies, examinations, choice of subjects or handicaps in expression. And social problems arise in connection with adjustments to friends in games and sports and in extra-curricular activities. Often the school organization is such that young people are neglected, for example, when the number of students on the roll is too large and nobody cares for anybody. Or the school administration is so autocratic and strict that young people have nothing to do but to obey and carry out the orders of the teacher and the headmaster. Or the school is run on very careless lines without any method or system, and the psychological needs of young people are neglected. The school is not a place where young people enjoy learning, gaining knowledge and organizing social and cultural programmes, but a place where they have only to mark time with indifferent and inefficient teachers.

The teacher is a vital part of the child's environment and with parents shares the role of making the destiny of the child. If he does his work with enthusiasm, earnestness and zest he will very easily transfer that feeling to his pupils. If instead of teaching mechanically lifeless facts from musty books he follows dynamic methods, makes learning a process of discovery and adventure and takes deep interest in the welfare and progress of his pupils young people will develop healthy intellectual interests which



they may carry into adult life. Usually teachers in Indian schools stress competition in studies and games and young people learn to work only for themselves. If he also encourages teamwork and group study children will learn valuable lessons in cooperation and group participation.

Some teachers bully and make fun of their pupils. This is very harmful to personality development. It may give a child feelings of inferiority or breed in him a resentment against the school and the teacher.

Gifted children are often made to sit idle in the class for the teacher is aiming to reach the average and mediocre pupils of the class, and they feel no interest in this type of teaching. They cannot sit still and do mischief. They feel useless and curse the teacher. Such children become problem children and develop personality difficulties.

#### *Mental hygiene in the college*

College students also need careful guidance and counselling, and with the type of violent indiscipline that prevails in colleges and universities today a suitable programme of counselling will prove very helpful. Almost anybody who can afford to pay fees joins a college in India without any consideration of his suitability for higher education. There are students who cannot study and concentrate, who cannot make friends with others or get along with them, and who join college without any purpose or aim. There are students who are afraid of examinations, who cannot talk in class and cannot write even a few sentences. There are students who shirk work and study, who are always complaining against teachers, principals and university authorities. Some students have physical defects, some are in conflict with their parents. There may be some who have special problems. All these types need advice from the psychiatrist so that they do not develop any personality difficulties. Generally interview therapy is given to students with some difficulty or problem.

#### *Psychiatric social worker*

The field of the psychiatric social worker is related to the social adjustments of the patient. To begin with he obtains the social history of the patient by interviewing him and his relatives

and friends, finds out his home conditions and family background and then advising him about his difficulties and problems and explaining them to his family also so that the home conditions may be understood by all concerned and improved if possible. May be that other members of the family also have emotional problems and the social worker in psychiatry tries to set the house in order literally. The patient may have occupational difficulties and may not be getting along well with his employer or colleagues. Thus his role in preventive measures is very significant. But in our country as yet there is no provision for the training of such psychiatric social workers. The number of young women committing suicide just after marriage, the number of young men running away from home or committing suicide after the examination results is not insignificant and so is the case with people disappointed in employment, marriage and the like and the social worker could be of very great help to such people.

### *Re-education*

We have described in this book the various techniques of treatment of mental disorders and illnesses. Their aim is to rebuild the personality of the individual so that he may be able to adjust to his physical and social environments to the best advantage of himself and society. In a broad sense all education has that aim. Not only formal education in the school but even informal education at home and outside is indirectly and directly aiming at the objective. This process is long and complicated, it has many pitfalls and there are many things which young people should not have learned as there are many things which they learn badly. For some of these defects only a little re-education is necessary. Experience and guidance of people around is enough to correct them and the individual himself may think over his behaviour and improve upon it. But some of them may need longer and more skilful treatment as has been described in this book. The aim of all psychotherapy and psychiatry is the re-education of the individual, a re-adjustment of maladjustments of many years' standing while medical and surgical treatment seeks to remove bacteria or growth processes which disturb physical health. But just as many people are able to keep good health



so many people are able to maintain sound mental health without any psychotherapy or psychiatry. Our great hope is that educative processes in the home, the school and society may be so improved that the individual is well adjusted to his physical and social environment and does not need any psychotherapy. This is easier said than done. We are living in a rapidly changing world and we do not know what sort of world the next generation shall have to live in. Material and social conditions due to the impact of science and technology are undergoing rapid and radical changes, and education cannot by any stretch of imagination anticipate them. All this is stressed in modern educational thought and practice is that the individual should be so educated that he should find his intellect and personality quite adequate to meet the challenge of changing conditions in an ever-changing world. This will not always be so and, therefore, preventive measures as mental hygiene suggests will have to be organized to safeguard the mental health of people. It is for society to rise to the occasion and show greater awareness of the need and importance of mental hygiene programmes for the masses. The return in terms of a community dedicated to the task of building a better world inhabited by saner people working for the good of all, for peace and prosperity, will increase manifold.

### QUESTIONS

1. Discuss the need and importance of mental hygiene.
2. What are the characteristics of a mentally healthy person?
3. Discuss what factors in an Indian home need improvement in the interest of mental health.
4. What are the common features of our schools which cause bad mental health?
5. From the point of view of mental hygiene what reforms would you like to bring about in Indian schools?
6. What do you understand by re-education? Explain briefly the aims and ideals of the mental hygiene movement?

## SUGGESTIONS FOR FURTHER STUDY

### *Text-books :*

- Page, J. D. :** Abnormal Psychology (McGraw-Hill Book Co.)  
**Maslow, A. H. & Mittelman, B. :** Principles of Abnormal Psychology (Harper & Bros.).  
**Coleman, J. C. :** Abnormal Psychology in Modern Life.  
**Fisher, V. E. :** An Introduction to Abnormal Psychology (Macmillan).  
**Conklin, E. S. :** Principles of Abnormal Psychology (Henry Holt).

### *Some original books recommended for general study :*

- Adler, A. :** The Practice and Theory of Abnormal Psychology.  
**Freud, S. :** Basic Writings of S. Freud.  
An Outline of Psychoanalysis.  
The Future of an Illusion.  
Civilization and Its Discontents.  
**Hadfield, G. E. :** Psychology and Mental Health.  
**Green, L. :** Mind in Action.  
**Horney, K. :** New Ways in Psychoanalysis.  
The Neurotic Personality of Our Time.  
Self-Analysis.  
Our Inner Conflict.  
**Klein, D. B. :** Mental Hygiene.  
**Fromm, E. :** Psychoanalysis and Religion.  
**Jung, C. G. :** Psychological Types.  
Modern Man in Search of Soul.



## ABNORMAL PSYCHOLOGY

### GLOSSARY

- Abreaction* : Giving expression to pent-up feelings and emotions.
- Abulia* : Lack of will power, utter inability to take a decision.
- Acrophobia* : Abnormal fear of high places.
- Affect* : Used as a noun to denote feelings of pleasure, emotions or moods.
- Agoraphobia* : Abnormal fear of being left alone in a wide open space.
- Ambivalence* : Feeling opposite emotions of love and hate for the same person at the same time.
- Ambivert* : Mixed personality type midway between introversion and extraversion.
- Amentia* : Mental deficiency.
- Amnesia* : Disorder of mind in which the patient is unable to recall past experiences or even recall who he is.
- Analgesia* : Loss of painful feeling, in whole or part.
- Anxiety Hysteria* : A type of hysteria put forward by Freud, in which hysteria is accompanied by deep fear and anxiety.
- Anxiety State* : A psychoneurosis marked by abnormal fear, tension and anxiety.
- Apathy* : A state of abnormal indifference and lack of feeling for any person, object or situation.
- Aphasia* : Loss of ability to understand and use language due to some brain injury or disease.
- Atrophy* : Wasting or shrinking of any part of the body.
- Auto-eroticism* : Obtaining sex gratification from one's own body. Love for oneself.
- Catharsis* : Setting the mind free from repressed wishes, emotions and memories which were unpleasant and embarrassing by giving expression to them. It is a term used in psychoanalysis.
- Censor* : A term used in psychoanalysis to indicate that a part of the Ego prevents unpleasant thoughts and memories of the unconscious from entering the conscious sphere.

*Claustrophobia* : Abnormal fear of closed space.

*Combat Fatigue* : The state of exhaustion produced by prolonged exposure to battle conditions, a term used in the Second World War.

*Compensation* : Making up for a defect or shortcoming. Behaviour which serves to make up for frustration or undesirable trait.

*Compulsion* : An impulse to action which one cannot resist even though one does not like it such as doing some unreasonable action again and again.

*Conflict* : A painful mental state in which opposing or contrary wishes, thoughts and needs are ranged against each other and are pulling the individual in opposite directions.

*Conversion Reaction or Hysteria* : Bodily behaviour such as loss of pain, paralysis due to mental tension or shocking experience.

*Cretin* : One suffering from birth mental deficiency and physical under-development due to deficiency of thyroid functioning.

*Defence Mechanism* : Mode of behaviour or thought adopted to save or protect one's esteem and prestige from feelings of guilt or blame.

*Delirium* : A disturbed state in which the individual feels restless, has illusions and hallucinations, and lacks knowledge of his environment.

*Delirium Tremens* : Intense state of delirium accompanied by shivering, fear.

*Delusions* : A false unreasonable belief.

*Dementia* : A condition of extreme mental disturbance, or degeneration.

*Dipsomania* : An abnormal craving for drink.

*Disorientation* : Lack of proper understanding of, or adjustment to, one's environment, time, place or person.

*Displacement* : Substituting one object for another to express our emotions.

*Dissociation* : Breaking or splitting up of personality into two or more parts.



*Echolalia* : A mental disorder in which the patient repeats whatever is said by another automatically.

*Electra Complex* : A complex of thoughts and emotions which a daughter directs toward her father, loving him and hating mother.

*Exhibitionism* : Extreme self-display of one's body and obtaining sex gratification from it.

*Extrovert* : One who directs all his thoughts and feelings to the outside world.

*Fetishism* : Arousing sex feelings and pleasure through some objects like kerchief or glove belonging to the person one loves.

*Fever Therapy* : Treating a person by inducing fever. Used mostly in curing paralysis.

*Free Association* : A technique of psychoanalysis in which the patient says everything that comes into his mind and thus reveals the contents of his unconscious.

*General Paresis* : Mental disorder resulting from progressive brain injury due to syphilis.

*Hydrotherapy* : Use of water, particularly baths, in the treatment of disease.

*Hypnoanalysis* : A technique of psychological treatment using hypnotism and psychoanalysis together.

*Hypnosis* : A trance state induced by heightened suggestion.

*Hysteria* : A form of psychoneurosis in which bodily ailments result from psychological troubles.

*Identification* : A mental mechanism in which an individual without being aware assumes the role of some other persons to get over his frustrations.

*Idiots Savants* : Mentally defective persons possessing some special talent.

*Inferiority Complex or Feeling* : Feelings that one is inadequate and not accepted by others.

*Introvert* : A type of person inclined more to think of his inner life and to seek solitude.

*Kleptomania* : Strong irresistible impulse to steal.

- Libido* : Sex drive, life force expressed in all forms of love.
- Masochism* : A form of sex disorder in which the person obtains sex gratification from being beaten or given some form of bodily torture.
- Mental Deficiency* : Mental weakness present from birth in which intelligence is below normal, and very weak.
- Mental Hygiene* : A movement whose objective is the prevention and treatment of mental illness, and the development of wholesome, effective and well-adjusted personality.
- Metrazol Therapy* : A form of treating mental disorders by injecting metrazol and thus bringing about convulsions. A type of shock treatment.
- Narcism* : Abnormal self-love which according to Freud is a necessary stage in sex development.
- Negativism* : Contrary behaviour, doing the opposite of what one is told.
- Neologism* : Coining new words which have no meaning.
- Nervous Breakdown* : An unscientific but popular term to denote any type of maladjustment or illness.
- Neurosis* : Same as psychoneurosis.
- Nyctophobia* : Abnormal fear of the dark.
- Obsession* : An unwanted idea persisting in mind.
- Oedipus Complex* : Freud believed that at one stage boys have sex desire for their mothers and this complex denotes such a fixation in which boys hate their father and love their mother.
- Orientation* : Adjustment to time, place, persons in the environment.
- Paranoia* : Mental illness marked by delusions of persecution and greatness.
- Paranoid* : One suffering from paranoia.
- Pathological* : Related to some disease, disorder or abnormality.
- Personality* : All that a person is psychologically, his interests, intelligence, habits, attitudes, likes and dislikes.
- Perversion* : An abnormality, a maladjustment, specially of sex behaviour.



*Phobia* : Violent fear, which persists and cannot be controlled.

*Prognosis* : Predicting the course and duration of a disorder or disease.

*Projection* : Attributing one's own thoughts, wishes, inhibitions, and faults to other persons or objects in the environment.

*Psychasthenia* : It is a general term for obsessive-compulsive reactions and phobias, but it is no longer popular.

*Psychiatry* : The branch of medicine dealing with the treatment of mental illness. A psychiatrist is a doctor specializing in the treatment of such diseases.

*Psychoanalysis* : A special technique making use of free association and dream-analysis to bring out memories, wishes and thoughts repressed in childhood.

*Psychogenic* : That which has a mental origin.

*Psychoneurosis* : A minor disorder or maladjustment marked by anxiety, fears, depression and bodily ailments with mental causes. It can only be psychologically treated.

*Psychopathic Personality* : A general term used to denote an unstable individual with anti-social traits and character defects.

*Psychopathology* : The science of disorders and disturbances of personality.

*Psychosis* : A major mental ailment involving serious disturbances of thought, emotion and bodily behaviour. It is a serious mental disease.

*Psychosexual* : Relating mental, social and physical aspects of sex.

*Psychosomatic* : An approach in medicine recognizing the importance of psychological and emotional factors in producing physical symptoms.

*Psychotherapy* : Treatment of mental disorders by psychological techniques.

*Pyromania* : Persistent impulse to set fire without any gain.

*Rapport* : Harmonious relation between the patient and the therapist in which the former has full confidence in the latter.

*Rationalization* : Unconscious use of untrue excuses or explanations to sustain one's ego or to make one appear in good light.

*Reaction Formation* : Checking undesirable traits by developing opposite traits.

*Regression* : Going back to childish behaviour when coping with frustrations and disagreeable situations.

*Repression* : Unconsciously keeping thoughts, memories of feelings out of the consciousness.

*Resistance* : Unwillingness or failure on the part of the patient to recall or communicate his close personal experiences to the therapist.

*Sadism* : A sex perversion in which the individual obtains sex excitement and pleasure by inflicting pain on others.

*Schizophrenia* : Functional psychosis marked by deep apathy, delusions, hallucinations, mannerisms, etc.

*Senile Dementia* : Mental disorder of old age marked by brain atrophy, loss of memory and increasing mental degeneration.

*Shell Shock* : Psychoneuroses brought about by exposure to battle conditions.

*Somnambulism* : Sleep-walking.

*Sublimation* : Redirecting frustrated sex desire or aggressiveness into higher channels.

*Syndrome* : A group of symptoms.

*Therapy* : Treatment.

*Tic* : A twitch or jerky movement occurring again and again.

*Transference* : In psychoanalysis establishment of emotional relations between the patient and the therapist.

*Trauma* : Injury or shock.

*Traumatic Psychosis* : Mental disease due to bodily injury or shock.

*War Neurosis* : Psychoneurosis among army personnel caused by war conditions.

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